2020-2021

Guide to Texas HMO Quality

OFFICE OF PUBLIC INSURANCE COUNSEL
TEXAS

This report is brought to you through a combined effort of the State of Texas,
the Office of Public Insurance Counsel, and the Department of State Health Services Center for Health Statistics.

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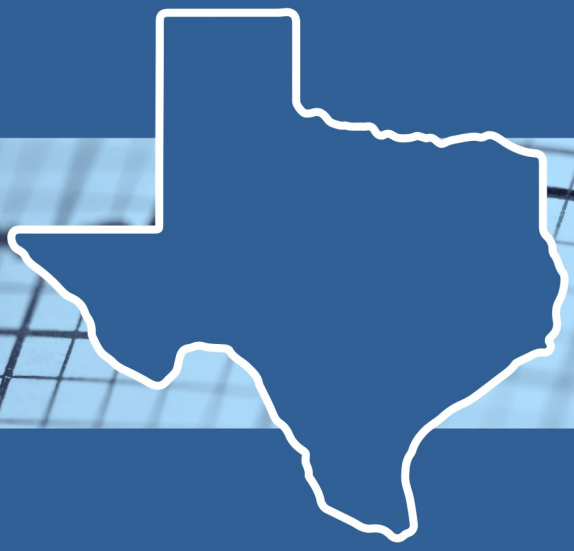

Section I

Introduction

Introduction

About the Report

The Office of Public Insurance Counsel (OPIC) is an independent state agency established by the Texas Legislature to represent the interests of Texas consumers in insurance matters. OPIC produces and publishes this report through a joint Memorandum of Understanding with the Department of State Health Services (DSHS) Center for Health Statistics. The ***Guide to Texas HMO Quality 2020-2021*** reports Health Maintenance Organization (HMO) performance based on quality of care measures. Consumers can use the publication to evaluate HMOs based on their own needs.

Section I of the report provides summary tables depicting HMO performance in specific categories. Section II details performance measures for each category of care. This section includes a narrative with an overview of each measure followed by bar charts that graphically depict the performance for all HMOs. Section III details performance measures for access and availability of care. Section IV provides utilization and risk-adjusted utilization measures. Section V details health plan descriptive information, including physician board certification and plan enrollment figures. The report concludes with Section VI on methods and statistical issues.

About the Data

The Healthcare Effectiveness Data and Information Set (HEDIS®)[1] is a set of standardized performance measures used to compare the quality of care of managed care organizations. The National Committee for Quality Assurance (NCQA), a private non-profit organization, developed and maintains HEDIS®. Each year NCQA convenes national health care experts to guide the selection and development of HEDIS® measures. The performance measures reflect many significant public health issues such as cancer, heart disease, smoking, diabetes, and the care of children and pregnant women. Texas law requires basic service HMOs to report HEDIS® measures each year to DSHS. For more information about the data or methodology used in this report, please consult Section VI at the end of this report.

Interpret the results in this publication with care. The data used in this report do not control for underlying differences in plan population characteristics like age or health status. For some measures, the difference between HMOs may represent differences in quality of care while others may simply represent a different mix of member enrollment. It is more meaningful to compare health plans across a group of related measures than any single measure.

Using the Report

OPIC encourages you to consider HEDIS® measures in relation to your specific needs. For example, if your family has young children, you may be interested in an HMO that performs well on childhood immunizations. If you are middle-aged, you may consider a plan that hires providers, such as doctors, who routinely screen for diseases for which you are at higher risk.

This guide is only one tool for comparing HMOs. You should consider other factors such as the service area, benefits, cost, availability of providers, and consumer satisfaction. Much of this information is available directly from the HMOs. You can find consumer satisfaction information in OPIC's publication ***Comparing Texas HMOs 2020-2021***, available at **www.opic.texas.gov**.

[1]HEDIS® - The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

Summary Tables

The summary tables provided in this section reflect a plan's performance on specific measures in relation to the Texas state average. The table summarizes plan performance as follows:

+ Plan performed better than the Texas average

= Plan performance equivalent to the Texas average

- Plan performance lower than the Texas average

The summary tables provide a quick tool to compare plan performance. The results should be interpreted with care. For some measures, the difference between HMOs may represent differences in quality of care, while others may simply represent a different mix of member enrollment. It is more meaningful to compare health plans across a group of related measures than any single measure. For detailed information on the statistical tests used in this publication, please consult Section VI at the end of this report.

Summary Tables

Health Plan Name	Childhood Immunization, DTaP	Childhood Immunization, IPV	Childhood Immunization, MMR	Childhood Immunization, HiB	Childhood Immunization, Hepatitis B	Childhood Immunization, VZV	Childhood Immunization, Pneumococcal Conjugate	Childhood Immunization, Hepatitis A	Childhood Immunization, Rotavirus
Aetna Health, Inc.*	=	=	-	=	=	-	=	=	=
Blue Cross Blue Shield of Texas (DFW)	-	-	=	-	-	=	-	=	-
Blue Cross Blue Shield of Texas (East/South/ West)	-	-	-	-	-	-	-	-	-
Blue Cross Blue Shield of Texas (Houston)	-	-	=	-	-	=	-	=	-
CHRISTUS Health Plan (Corpus Christi)	NA	NA	NA	NA	NA	NA	NA	NA	NA
Cigna Healthcare of Texas, Inc. (Houston/Dallas)*	=	+	=	=	-	=	=	+	=
Community First Health Plans, Inc.*	+	+	+	+	+	+	+	=	+
FIRSTCARE (Abilene/Waco)	=	=	=	=	+	=	=	=	+
FIRSTCARE (Amarillo)	+	+	+	+	+	+	+	-	+
FIRSTCARE (Lubbock)	+	+	+	+	+	+	=	+	=
Humana Health Plan of Texas (Austin)*	-	=	-	-	=	-	=	-	=
Humana Health Plan of Texas (Corpus Christi)*	=	=	=	=	-	=	=	=	=
Humana Health Plan of Texas (Houston)*	=	=	=	=	-	=	=	=	=
Humana Health Plan of Texas (San Antonio)*	=	=	=	=	+	=	=	=	=
Memorial Hermann Health Plan (Houston)	+	+	=	+	+	=	+	=	+
Scott and White Health Plan (Central Texas)*	+	+	+	+	+	+	+	+	+
United Healthcare of Texas, Inc. (Austin/San Antonio)*	+	+	+	+	+	+	+	+	+
United Healthcare of Texas, Inc. (DFW)*	NA	NA	NA	NA	NA	NA	NA	NA	NA
United Healthcare of Texas, Inc. (Houston/Corpus Christi)*	NA	NA	NA	NA	NA	NA	NA	NA	NA

+ Higher than Texas Average **= Equivalent to Texas Average** **- Lower than Texas Average**

NA – Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

NR – Not Reported. The organization chose not to report the measure.

NQ – Not Required. The organization was not required to report the measure.

** Plans reporting HMO/POS membership combined. Others are HMO membership only.*

Summary Tables

Health Plan Name	Childhood Immunization, Influenza	Childhood Immunization, Combination 2	Childhood Immunization, Combination 3	Childhood Immunization, Combination 4	Childhood Immunization, Combination 5	Childhood Immunization, Combination 6	Childhood Immunization, Combination 7	Childhood Immunization, Combination 8	Childhood Immunization, Combination 9
Aetna Health, Inc.*	=	=	=	=	=	=	=	=	=
Blue Cross Blue Shield of Texas (DFW)	=	-	-	-	-	-	-	-	-
Blue Cross Blue Shield of Texas (East/South/ West)	-	-	-	-	-	-	-	-	-
Blue Cross Blue Shield of Texas (Houston)	-	-	-	-	-	-	-	-	-
CHRISTUS Health Plan (Corpus Christi)	NA	NA	NA	NA	NA	NA	NA	NA	NA
Cigna Healthcare of Texas, Inc. (Houston/Dallas)*	+	-	-	-	-	-	-	-	-
Community First Health Plans, Inc.*	+	+	+	+	+	+	+	+	+
FIRSTCARE (Abilene/Waco)	+	+	+	+	+	+	+	+	+
FIRSTCARE (Amarillo)	=	+	+	=	+	=	=	=	=
FIRSTCARE (Lubbock)	=	+	+	+	=	=	=	=	=
Humana Health Plan of Texas (Austin)*	=	+	=	=	=	=	=	=	=
Humana Health Plan of Texas (Corpus Christi)*	=	-	-	-	-	-	-	-	-
Humana Health Plan of Texas (Houston)*	=	=	=	=	=	=	=	=	=
Humana Health Plan of Texas (San Antonio)*	=	+	+	+	+	+	+	+	+
Memorial Hermann Health Plan (Houston)	=	+	+	+	+	+	+	+	+
Scott and White Health Plan (Central Texas)*	=	+	+	+	+	+	+	+	+
United Healthcare of Texas, Inc. (Austin/San Antonio)*	=	+	+	+	+	+	+	+	+
United Healthcare of Texas, Inc. (DFW)*	NA	NA	NA	NA	NA	NA	NA	NA	NA
United Healthcare of Texas, Inc. (Houston/Corpus Christi)*	NA	NA	NA	NA	NA	NA	NA	NA	NA

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Summary Tables

Health Plan Name	Childhood Immunization, Combination 10	Breast Cancer Screening	Cervical Cancer Screening	Non-Recommended Cervical Cancer Screening in Adolescent Females	Colorectal Cancer Screening	Chlamydia Screening, Women (16-20)	Chlamydia Screening, Women (21-24)	Chlamydia Screening, Women (Total)	Controlling High Blood Pressure
Aetna Health, Inc.*	=	=	=	=	+	+	=	+	+
Blue Cross Blue Shield of Texas (DFW)	-	-	-	+	-	-	=	-	-
Blue Cross Blue Shield of Texas (East/South/ West)	-	-	-	=	-	-	-	-	-
Blue Cross Blue Shield of Texas (Houston)	-	-	-	=	-	=	=	=	-
CHRISTUS Health Plan (Corpus Christi)	NA	=	-	+	+	=	NA	=	+
Cigna Healthcare of Texas, Inc. (Houston/Dallas)*	-	+	+	-	+	+	+	+	-
Community First Health Plans, Inc.*	+	-	=	=	+	+	=	+	+
FIRSTCARE (Abilene/Waco)	+	-	-	+	=	-	-	-	+
FIRSTCARE (Amarillo)	=	-	=	=	-	-	-	-	+
FIRSTCARE (Lubbock)	=	-	-	+	-	-	-	-	+
Humana Health Plan of Texas (Austin)*	=	=	=	-	=	=	=	-	+
Humana Health Plan of Texas (Corpus Christi)*	-	=	=	=	=	=	=	=	+
Humana Health Plan of Texas (Houston)*	=	-	=	=	=	=	=	=	+
Humana Health Plan of Texas (San Antonio)*	+	-	=	-	+	-	-	-	+
Memorial Hermann Health Plan (Houston)	+	-	-	=	-	=	=	=	+
Scott and White Health Plan (Central Texas)*	+	+	=	-	+	-	-	-	+
United Healthcare of Texas, Inc. (Austin/San Antonio)*	+	-	=	=	-	=	=	-	+
United Healthcare of Texas, Inc. (DFW)*	NA	-	-	=	-	=	=	=	+
United Healthcare of Texas, Inc. (Houston/Corpus Christi)*	NA	-	=	=	-	+	=	+	+

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Summary Tables

Health Plan Name	Persistence of Beta-Blocker Treatment After Heart Attack	Statin Therapy with Cardio-vascular Disease: Received Therapy (Males 21-75)	Statin Therapy with Cardiovascular Disease: Adherence 80% (Males 21-75)	Statin Therapy with Cardio-vascular Disease: Received Therapy (Females 40-75)	Statin Therapy with Cardio-vascular Disease: Adherence 80% (Females 40-75)	Statin Therapy with Cardio-vascular Disease: Received Therapy (Total)	Statin Therapy with Cardiovascular Disease: Adherence 80% (Total)	Diabetes Care, HbA1c Testing	Diabetes Care, HbA1c > 9.0%
Aetna Health, Inc.*	NA	=	=	=	=	=	=	=	=
Blue Cross Blue Shield of Texas (DFW)	=	=	=	=	=	=	=	=	=
Blue Cross Blue Shield of Texas (East/South/ West)	=	=	=	=	=	=	=	-	+
Blue Cross Blue Shield of Texas (Houston)	NA	=	=	=	=	=	=	-	=
CHRISTUS Health Plan (Corpus Christi)	NA	-	=	-	=	-	=	=	+
Cigna Healthcare of Texas, Inc. (Houston/Dallas)*	=	+	=	+	=	+	-	+	-
Community First Health Plans, Inc.*	NA	+	=	=	=	=	=	=	-
FIRSTCARE (Abilene/Waco)	NA	=	=	NA	NA	=	=	=	+
FIRSTCARE (Amarillo)	NA	=	=	=	NA	=	=	=	+
FIRSTCARE (Lubbock)	NA	-	=	-	NA	-	=	=	+
Humana Health Plan of Texas (Austin)*	NA	=	=	=	=	=	=	=	-
Humana Health Plan of Texas (Corpus Christi)*	NA	=	=	NA	NA	=	=	=	-
Humana Health Plan of Texas (Houston)*	NA	=	=	=	=	=	=	=	-
Humana Health Plan of Texas (San Antonio)*	=	=	=	=	=	=	+	=	-
Memorial Hermann Health Plan (Houston)	NA	NA	NA	NA	NA	=	NA	-	-
Scott and White Health Plan (Central Texas)*	=	+	=	+	=	+	+	=	-
United Healthcare of Texas, Inc. (Austin/San Antonio)*	NA	=	=	NA	NA	=	-	=	-
United Healthcare of Texas, Inc. (DFW)*	NA	NA	NA	NA	NA	=	=	+	-
United Healthcare of Texas, Inc. (Houston/Corpus Christi)*	NA	NA	NA	NA	NA	NA	NA	=	-

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Summary Tables

Health Plan Name	Diabetes Care, HbA1c < 8.0%	Diabetes Care, HbA1c < 7.0%	Diabetes Care, Eye Exams	Diabetes Care, Medical Attention for Nephropathy	Diabetes Care, Blood Pressure < 140/90 mm Hg	Statin Therapy for Patients with Diabetes: Received Therapy	Statin Therapy for Patients with Diabetes: Statin Adherence 80%	Testing for Children With Pharyngitis	Treatment for Children With URI
Aetna Health, Inc.*	=	NR	+	=	+	+	+	-	=
Blue Cross Blue Shield of Texas (DFW)	=	NR	-	-	-	=	=	=	=
Blue Cross Blue Shield of Texas (East/South/ West)	-	NR	-	-	-	=	-	=	=
Blue Cross Blue Shield of Texas (Houston)	=	NR	-	-	-	=	=	+	=
CHRISTUS Health Plan (Corpus Christi)	-	NR	+	=	+	=	=	=	-
Cigna Healthcare of Texas, Inc. (Houston/Dallas)*	+	NR	=	+	-	+	-	+	-
Community First Health Plans, Inc.*	+	NR	+	=	+	=	=	-	+
FIRSTCARE (Abilene/Waco)	-	NR	=	-	+	=	+	=	-
FIRSTCARE (Amarillo)	-	NR	=	=	+	-	+	-	-
FIRSTCARE (Lubbock)	-	NR	-	-	=	-	+	=	=
Humana Health Plan of Texas (Austin)*	+	NQ	+	=	+	=	+	+	+
Humana Health Plan of Texas (Corpus Christi)*	+	NQ	+	=	+	=	-	-	=
Humana Health Plan of Texas (Houston)*	+	NQ	+	=	+	=	=	+	=
Humana Health Plan of Texas (San Antonio)*	+	NQ	+	=	+	=	+	=	+
Memorial Hermann Health Plan (Houston)	+	=	-	=	+	=	=	+	=
Scott and White Health Plan (Central Texas)*	+	NR	+	=	+	=	+	=	+
United Healthcare of Texas, Inc. (Austin/San Antonio)*	+	NR	=	=	+	=	-	=	+
United Healthcare of Texas, Inc. (DFW)*	+	NR	=	=	+	=	-	=	=
United Healthcare of Texas, Inc. (Houston/Corpus Christi)*	+	NR	=	=	+	=	-	=	=

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Summary Tables

Health Plan Name	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Med Management for Asthma, On Meds for 50% of Treatment (5-11)	Med Management for Asthma, On Meds for 50% of Treatment (12-18)	Med Management for Asthma, On Meds for 50% of Treatment (19-50)	Med Management for Asthma, On Meds for 50% of Treatment (51-64)	Med Management for Asthma, On Meds for 50% of Treatment (Total)	Med Management for Asthma, On Meds for 75% of Treatment (5-11)	Med Management for Asthma, On Meds for 75% of Treatment (12-18)	Med Management for Asthma, On Meds for 75% of Treatment (19-50)
Aetna Health, Inc.*	=	NA	NA	=	=	=	NA	NA	=
Blue Cross Blue Shield of Texas (DFW)	=	NA	NA	=	=	=	NA	NA	=
Blue Cross Blue Shield of Texas (East/South/ West)	+	=	NA	=	=	=	-	NA	=
Blue Cross Blue Shield of Texas (Houston)	-	NA	NA	=	=	=	NA	NA	=
CHRISTUS Health Plan (Corpus Christi)	-	NA	NA	NA	NA	NA	NA	NA	NA
Cigna Healthcare of Texas, Inc. (Houston/Dallas)*	-	=	NA	-	-	-	=	NA	-
Community First Health Plans, Inc.*	+	=	=	=	+	+	=	=	=
FIRSTCARE (Abilene/Waco)	-	NA	NA	=	=	=	NA	NA	=
FIRSTCARE (Amarillo)	-	NA	NA	=	=	=	NA	NA	=
FIRSTCARE (Lubbock)	+	NA	=	=	=	=	NA	=	=
Humana Health Plan of Texas (Austin)*	+	NA	NA	=	=	=	NA	NA	=
Humana Health Plan of Texas (Corpus Christi)*	=	NA	NA	NA	NA	=	NA	NA	NA
Humana Health Plan of Texas (Houston)*	=	NA	NA	=	=	=	NA	NA	=
Humana Health Plan of Texas (San Antonio)*	=	=	=	=	=	=	-	=	=
Memorial Hermann Health Plan (Houston)	=	NA	NA	NA	NA	NA	NA	NA	NA
Scott and White Health Plan (Central Texas)*	=	=	=	=	=	=	=	=	=
United Healthcare of Texas, Inc. (Austin/San Antonio)*	+	NA	NA	=	NA	=	NA	NA	=
United Healthcare of Texas, Inc. (DFW)*	=	NA	NA	NA	NA	NA	NA	NA	NA
United Healthcare of Texas, Inc. (Houston/Corpus Christi)*	=	NA	NA	NA	NA	NA	NA	NA	NA

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Summary Tables

Health Plan Name	Med Management for Asthma, On Meds for 75% of Treatment (51-64)	Med Management for Asthma, On Meds for 75% of Treatment (Total)	Antidepressant Med Management, Acute Phase	Antidepressant Med Management, Continuation Phase	Follow-Up Care: Children Prescribed ADHD Meds, Initiation Phase	Follow-Up Care: Children Prescribed ADHD Meds, Continuation & Maintenance	7-Day Follow-Up after Hospitalization for Mental Illness	30-Day Follow-Up after Hospitalization for Mental Illness	7-Day Follow-Up After ED Visit for Mental Illness
Aetna Health, Inc.*	=	=	=	+	=	NA	=	=	NA
Blue Cross Blue Shield of Texas (DFW)	=	=	=	=	=	NA	=	=	=
Blue Cross Blue Shield of Texas (East/South/ West)	=	=	=	=	=	NA	-	-	=
Blue Cross Blue Shield of Texas (Houston)	=	=	=	=	=	NA	=	=	NA
CHRISTUS Health Plan (Corpus Christi)	NA	NA	+	=	NA	NA	NA	NA	NA
Cigna Healthcare of Texas, Inc. (Houston/Dallas)*	=	-	-	-	=	=	=	+	=
Community First Health Plans, Inc.*	=	=	-	=	+	NA	=	=	NA
FIRSTCARE (Abilene/Waco)	=	=	=	=	=	NA	NA	NA	NA
FIRSTCARE (Amarillo)	=	=	+	=	=	NA	NA	NA	NA
FIRSTCARE (Lubbock)	=	=	+	+	=	NA	NA	NA	NA
Humana Health Plan of Texas (Austin)*	=	=	+	+	=	NA	=	=	=
Humana Health Plan of Texas (Corpus Christi)*	NA	=	=	-	NA	NA	NA	NA	NA
Humana Health Plan of Texas (Houston)*	=	=	=	=	=	NA	=	=	NA
Humana Health Plan of Texas (San Antonio)*	=	=	=	=	=	NA	=	=	NA
Memorial Hermann Health Plan (Houston)	NA	NA	=	+	NA	NA	NA	NA	NA
Scott and White Health Plan (Central Texas)*	=	=	=	=	=	=	=	=	=
United Healthcare of Texas, Inc. (Austin/San Antonio)*	NA	=	=	=	NA	NA	=	=	NA
United Healthcare of Texas, Inc. (DFW)*	NA	NA	=	=	NA	NA	NA	NA	NA
United Healthcare of Texas, Inc. (Houston/Corpus Christi)*	NA	NA	-	=	NA	NA	NA	NA	NA

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** Plans reporting HMO/POS membership combined. Others are HMO membership only.*

Summary Tables

Health Plan Name	30-Day Follow-Up After ED Visit for Mental Illness	7-Day Follow-Up After ED Visit for Alcohol & Other Drug Dependence (13-17)	7-Day Follow-Up After ED Visit for Alcohol & Other Drug Dependence (18+)	7-Day Follow-Up After ED Visit for Alcohol & Other Drug Dependence (Total)	30-Day Follow-Up After ED Visit for Alcohol & Other Drug Dependence (13-17)	30-Day Follow-Up After ED Visit for Alcohol & Other Drug Dependence (18+)	30-Day Follow-Up After ED Visit for Alcohol & Other Drug Dependence (Total)	Adult Access to Preventative/ Ambulatory Services (20-44)	Adult Access to Preventative/ Ambulatory Services (45-64)
Aetna Health, Inc.*	NA	NA	=	NA	NA	=	=	+	+
Blue Cross Blue Shield of Texas (DFW)	=	NA	=	=	NA	=	=	-	-
Blue Cross Blue Shield of Texas (East/South/ West)	-	NA	=	=	NA	=	=	-	-
Blue Cross Blue Shield of Texas (Houston)	NA	NA	=	NA	NA	=	=	-	-
CHRISTUS Health Plan (Corpus Christi)	NA	NA	NA	NA	NA	=	=	=	=
Cigna Healthcare of Texas, Inc. (Houston/Dallas)*	=	NA	=	=	NA	=	=	+	+
Community First Health Plans, Inc.*	NA	NA	NA	NA	NA	=	=	+	+
FIRSTCARE (Abilene/Waco)	NA	NA	NA	NA	NA	=	=	+	+
FIRSTCARE (Amarillo)	NA	NA	NA	NA	NA	=	=	+	+
FIRSTCARE (Lubbock)	NA	NA	NA	NA	NA	=	=	+	+
Humana Health Plan of Texas (Austin)*	=	NA	=	=	NA	=	=	+	=
Humana Health Plan of Texas (Corpus Christi)*	NA	NA	NA	NA	NA	=	=	=	=
Humana Health Plan of Texas (Houston)*	NA	NA	NA	NA	NA	=	=	=	-
Humana Health Plan of Texas (San Antonio)*	NA	NA	=	=	NA	=	=	=	=
Memorial Hermann Health Plan (Houston)	NA	NA	NA	NA	NA	+	+	-	-
Scott and White Health Plan (Central Texas)*	=	NA	=	=	NA	=	=	+	+
United Healthcare of Texas, Inc. (Austin/San Antonio)*	NA	NA	NA	NA	NA	=	=	=	=
United Healthcare of Texas, Inc. (DFW)*	NA	NA	NA	NA	NA	=	=	-	-
United Healthcare of Texas, Inc. (Houston/Corpus Christi)*	NA	NA	NA	NA	NA	=	=	-	-

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Summary Tables

Health Plan Name	Adult Access to Preventative/ Ambulatory Services (65+)	Adult Access to Preventative/ Ambulatory Services (Total)	Timeliness of Prenatal Care	Postpartum Care	Well Child Visits: First 15 Months of Life	Well Child Visits: 3-6	Adolescent Well-Care Visits
Aetna Health, Inc.*	=	+	-	-	=	=	=
Blue Cross Blue Shield of Texas (DFW)	-	-	-	-	+	=	=
Blue Cross Blue Shield of Texas (East/South/ West)	-	-	-	-	-	-	-
Blue Cross Blue Shield of Texas (Houston)	-	-	=	-	=	-	-
CHRISTUS Health Plan (Corpus Christi)	+	+	NA	NA	NA	=	-
Cigna Healthcare of Texas, Inc. (Houston/Dallas)*	-	+	-	-	=	+	+
Community First Health Plans, Inc.*	=	+	+	+	=	=	-
FIRSTCARE (Abilene/Waco)	=	+	+	+	=	=	-
FIRSTCARE (Amarillo)	=	+	=	=	=	=	-
FIRSTCARE (Lubbock)	=	+	-	=	=	-	-
Humana Health Plan of Texas (Austin)*	=	=	+	+	=	+	+
Humana Health Plan of Texas (Corpus Christi)*	=	=	+	+	=	=	-
Humana Health Plan of Texas (Houston)*	=	-	+	+	=	=	=
Humana Health Plan of Texas (San Antonio)*	-	=	+	+	=	+	=
Memorial Hermann Health Plan (Houston)	-	-	+	+	NA	-	-
Scott and White Health Plan (Central Texas)*	+	+	+	+	+	=	=
United Healthcare of Texas, Inc. (Austin/San Antonio)*	=	-	+	+	=	+	=
United Healthcare of Texas, Inc. (DFW)*	-	-	+	+	NA	=	=
United Healthcare of Texas, Inc. (Houston/Corpus Christi)*	=	-	+	+	=	-	=

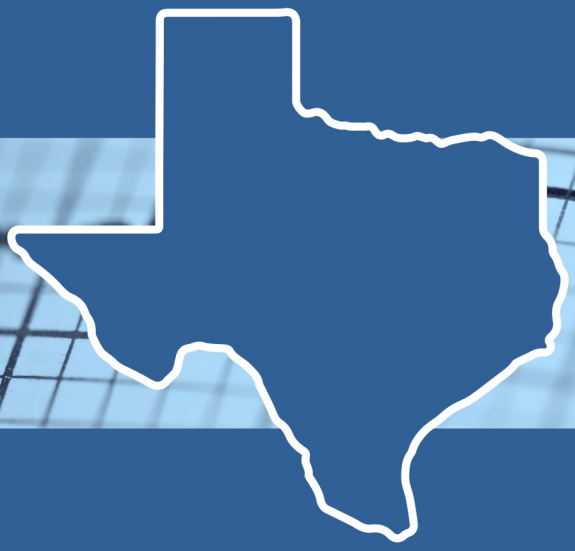
+ Higher than Texas Average **= Equivalent to Texas Average** **- Lower than Texas Average**

NA – Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

NR – Not Reported. The organization chose not to report the measure.

NQ – Not Required. The organization was not required to report the measure.

** Plans reporting HMO/POS membership combined. Others are HMO membership only.*



Section II

Effectiveness of Care

Effectiveness of Care

Prevention and Screening

Childhood Immunization Status: Diphtheria, Tetanus, and acellular Pertussis (DTaP)

DEFINITION:

The percentage of children using the HMO who received at least 4 doses of the Diphtheria, Tetanus, acellular Pertussis (DTaP) vaccine by the age of 2.

Diphtheria is a bacterial respiratory infection characterized by a sore throat, low-grade fever, a coating in the back of the throat, and a swollen neck. The disease is spread by coughing and sneezing. Complications include breathing problems, paralysis, heart failure, and death.[1]

Tetanus (lockjaw) is a bacterial infection caused by exposure through cuts in the skin. The disease causes painful tightening of the muscles and can cause the jaw to "lock" closed. Tetanus leads to death in about 1 in 10 cases.[2]

Pertussis (whooping cough) is a highly contagious bacterial respiratory disease spread by coughing and sneezing. The patient experiences severe spasms of coughing that often last minutes. Between coughing spells, the patient may gasp for air with a characteristic "whooping" sound. If left untreated, pertussis may lead to pneumonia (a lung infection), seizures, encephalopathy (brain degeneration), vomiting, weight loss, breathing difficulties, and possibly death.[3]

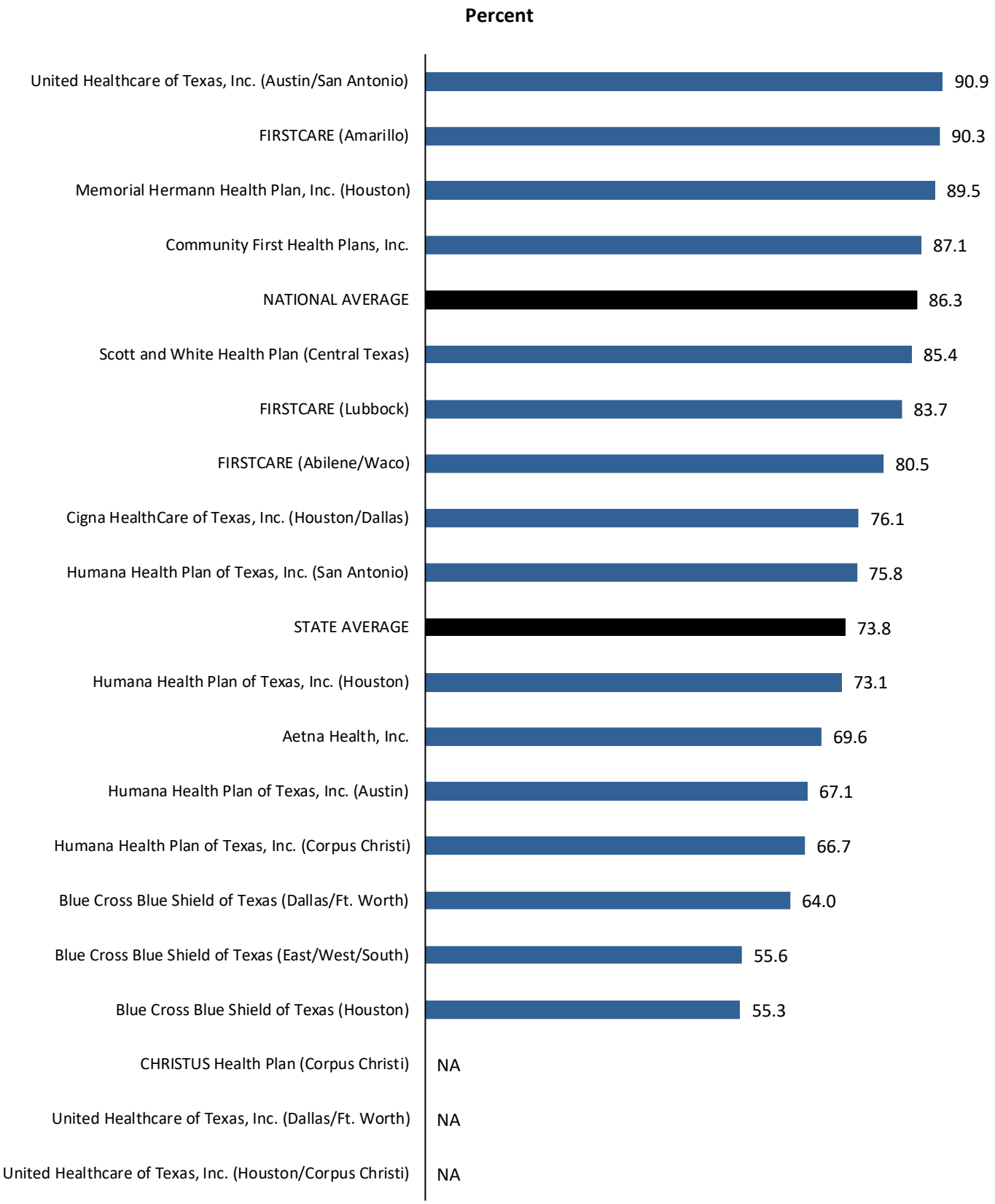
Four combination vaccines prevent diphtheria, tetanus, and acellular pertussis: DTaP, Tdap, DT, and Td. Children under 7 get DTaP and DT. Tdap and Td are given to adolescents and adults. DT and Td are given to individuals who cannot receive the pertussis vaccine. Upper-case letters indicate full-strength doses of diphtheria and pertussis in child formulas and lower-case letters indicate reduced doses given in the adolescent/adult formulas. The lowercase "a" indicates that the pertussis vaccine is "acellular."[4]

DTaP					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	75.1%	75.3%	76.8%	78.0%	73.8%
NCQA's Quality Compass®	85.9%	85.3%	85.3%	85.8%	86.3%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

[1] Hamborsky, Jennifer, Andrew Kroger, and Charles Wolfe, eds. Centers for Disease Control and Prevention. *Epidemiology and Prevention of Vaccine-Preventable Diseases*. 13th ed. Washington, D.C.: Public Health Foundation, 2015.
[2] Ibid.
[3] Ibid.
[4] Ibid.

DTaP



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Childhood Immunization Status:
Polio (IPV)

DEFINITION:

The percentage of children using the HMO who received at least 3 doses of the Inactivated Polio Vaccine (IPV) by the age of 2.

Polio is a viral disease that lives in the throat and intestinal tract. It typically spreads through contact with the stool of an infected person, but may also spread through oral/nasal secretions. Before the vaccine was introduced in 1955, polio caused paralysis in thousands of people in the U.S. each year. Most people infected with the polio virus have no symptoms. About 4-8% of those infected experience flu-like symptoms that resolve without causing permanent injury. Approximately 1-2% of infected individuals experience stiffness of the neck, back, or legs. Fewer than 1% of the total cases result in paralysis which can lead to permanent disability or death.[1]

IPV					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	80.7%	82.2%	83.1%	85.4%	79.7%
NCQA's Quality Compass®	90.7%	90.4%	90.6%	91.3%	91.3%

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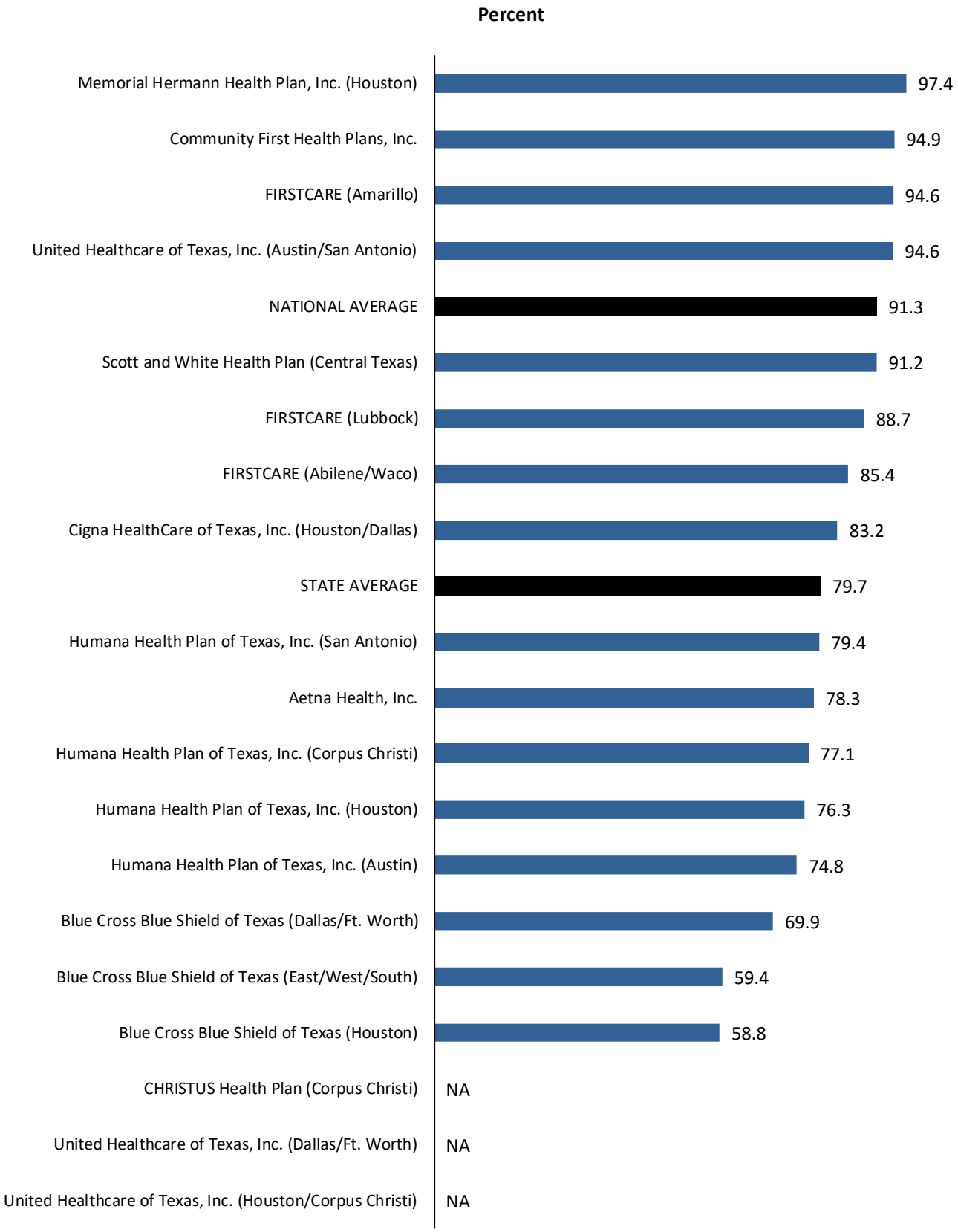
IPV



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Childhood Immunization Status: Measles, Mumps, and Rubella (MMR)

DEFINITION:

The percentage of children using the HMO who received at least 1 dose of the Measles, Mumps, and Rubella (MMR) vaccine by the age of 2.

Measles is a highly contagious viral disease that causes rash, cough, runny nose, eye irritation, and fever. Complications include ear infection, pneumonia (a lung infection), seizures, brain damage, or death. Measles infection was nearly universal before a vaccine was available.

Mumps is a viral disease that causes fever, headache, and swollen salivary glands. It can cause serious complications like hearing loss, encephalitis (inflammation of the brain), and meningitis (inflammation of the coverings of the brain and spinal cord).

Rubella (German Measles) is a viral disease that causes rash, mild fever, and arthritis. The disease is typically mild in children and young adults. However, a woman who contracts rubella during pregnancy may spread the disease to the fetus. The condition, Congenital Rubella Syndrome (CRS), can result in miscarriage, stillbirth, or severe birth defects. The most common birth defects are blindness, deafness, heart damage, and intellectual disabilities.

MMR					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	92.7%	91.1%	91.7%	90.8%	90.2%
NCQA's Quality Compass®	93%	92.8%	92.5%	92.3%	92.6%

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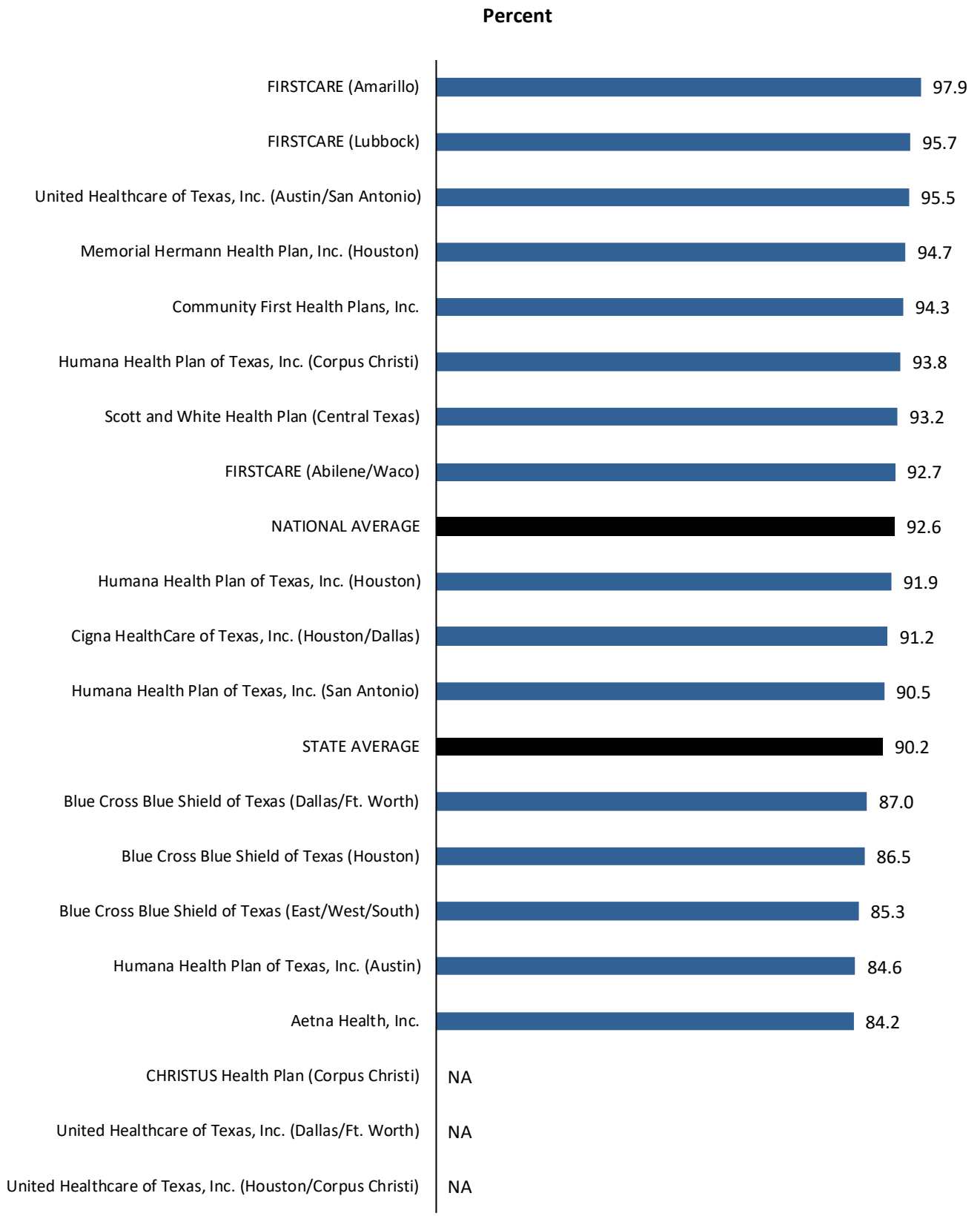
MMR



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Childhood Immunization Status: Haemophilius Influenzae Type B (HiB)

DEFINITION:

The percentage of children using the HMO who received at least 3 doses of the *Haemophilus influenzae* type B (HiB) vaccine by the age of 2.

HiB is a bacterial infection that can cause meningitis (an infection of the covering of the brain and spinal cord), pneumonia (a lung infection), epiglottitis (a severe throat infection), and other life-threatening conditions. HiB was the leading cause of bacterial meningitis and other invasive bacterial disease among children younger than 5 before the introduction of effective vaccines in the mid-1980s. Prior to the development of vaccines, approximately two-thirds of all HiB cases occurred among children younger than 18 months. The routine use of the HiB conjugate vaccine has reduced the incidence of HiB in infants and young children by 99% since the introduction of the vaccine.[1]

HiB					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	82.6%	85.3%	85.2%	87.2%	82.6%
NCQA's Quality Compass®	91.9%	91.3%	91.6%	91.4%	91.7%

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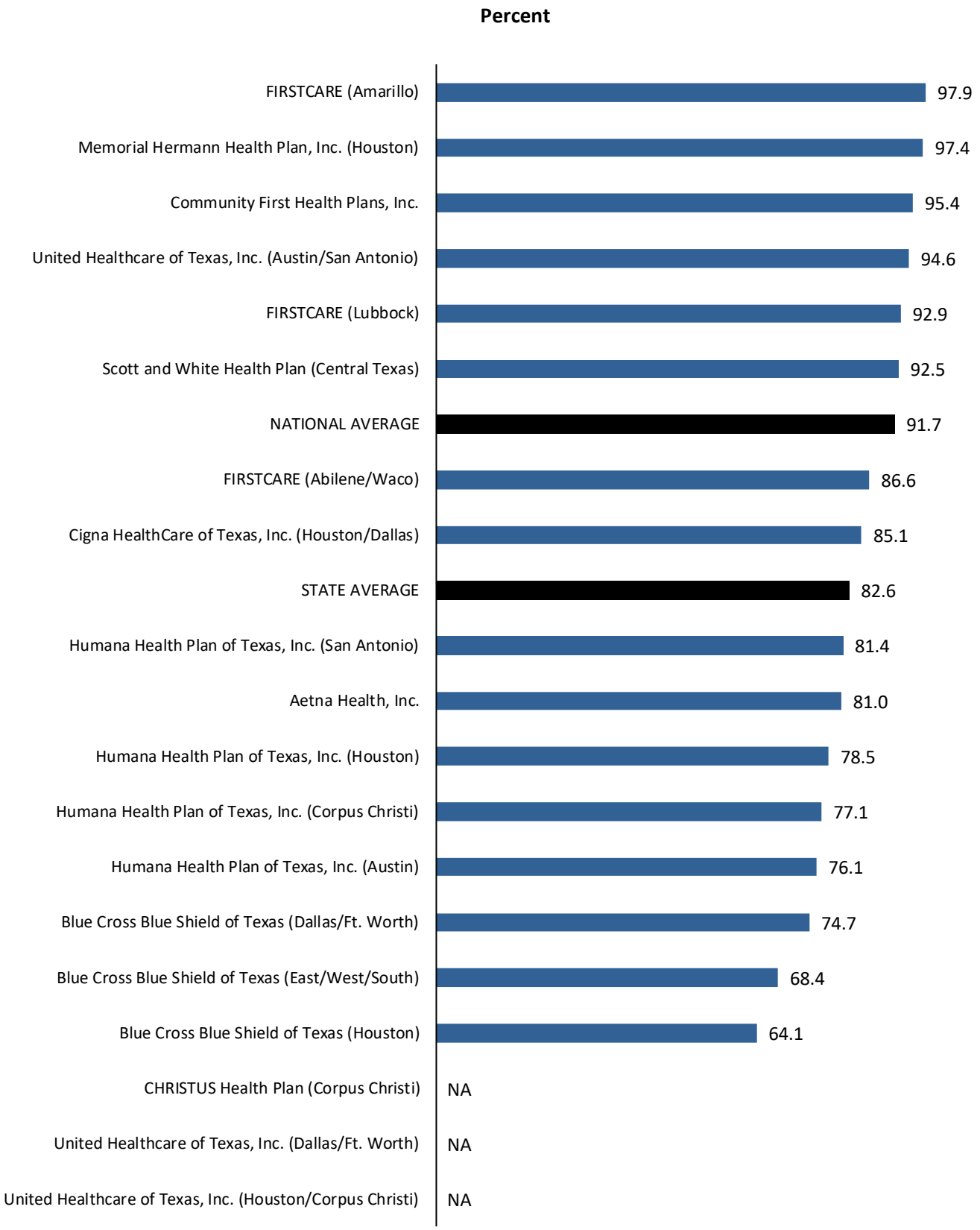
[1] Hamborsky, Jennifer, Andrew Kroger, and Charles Wolfe, eds. Centers for Disease Control and Prevention. *Epidemiology and Prevention of Vaccine-Preventable Diseases*. 13th ed. Washington, D.C.: Public Health Foundation, 2015.

HiB



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Childhood Immunization Status: Hepatitis B (HBV)

DEFINITION:

The percentage of children using the HMO who received 3 doses of the Hepatitis B (HBV) vaccine by the age of 2.

HBV is a virus that spreads through contact with an infected person's body fluids. Symptoms of HBV include jaundice (yellow coloration of the skin and eyes), fatigue, abdominal pain, loss of appetite, nausea, vomiting, and joint pain. Complications include cirrhosis (liver damage) and liver cancer. Once infected, children are less likely than adults to experience severe symptoms associated with acute HBV infection, but they are more likely to experience chronic infection. Complications are more likely with chronic infection. Approximately 90% of infants and 30-50% of children under 5 will remain chronically infected. Vaccination for HBV reduces or eliminates the risk of contracting the disease for at least 20 years in healthy individuals vaccinated after 6 months.[1]

HBV					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	75.6%	65.8%	69.8%	77.6%	58.7%
NCQA's Quality Compass®	86.5%	85.4%	86.3%	87.3%	86.7%

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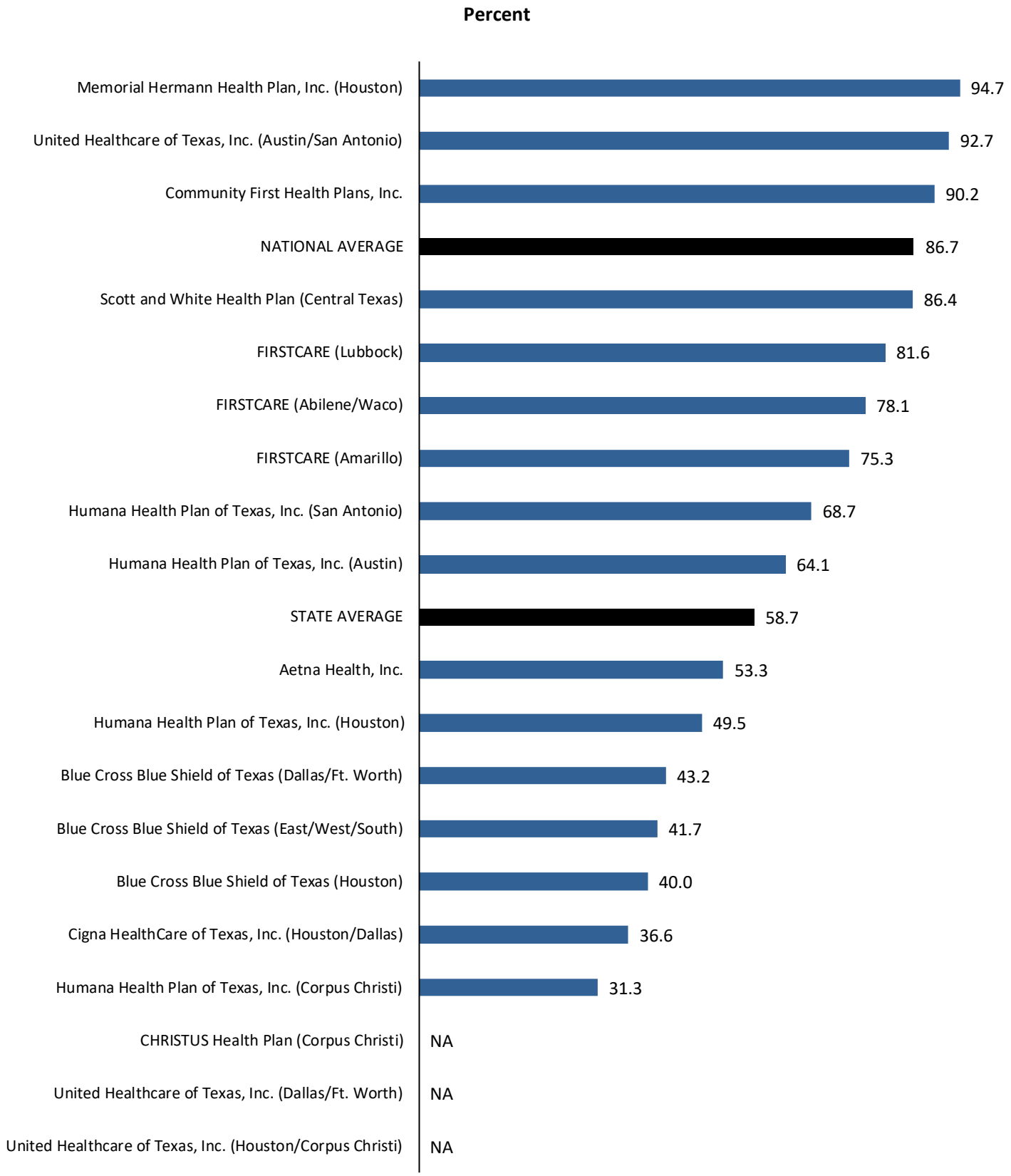
[1] Hamborsky, Jennifer, Andrew Kroger, and Charles Wolfe, eds. Centers for Disease Control and Prevention. *Epidemiology and Prevention of Vaccine-Preventable Diseases*. 13th ed. Washington, D.C.: Public Health Foundation, 2015.

HBV



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Childhood Immunization Status: Chickenpox (VZV)

DEFINITION:

The percentage of children using the HMO who received at least 1 dose of the Chickenpox, also known as varicella-zoster virus (VZV), vaccine by the age of 2.

Chickenpox is a virus that causes fever and rash. Complications include skin infection, encephalitis (inflammation of the brain), and pneumonia (a lung infection). Adolescents and adults who contract the disease have a greater risk of complications. The vaccine completely protects 80-90% of individuals from the disease. Those who receive the vaccine but are not completely immune typically experience a milder version of the illness.[1]

VZV					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	92.3%	90.7%	91.3%	90.5%	89.7%
NCQA's Quality Compass®	91.9%	90.2%	92.0%	92.0%	92.0%

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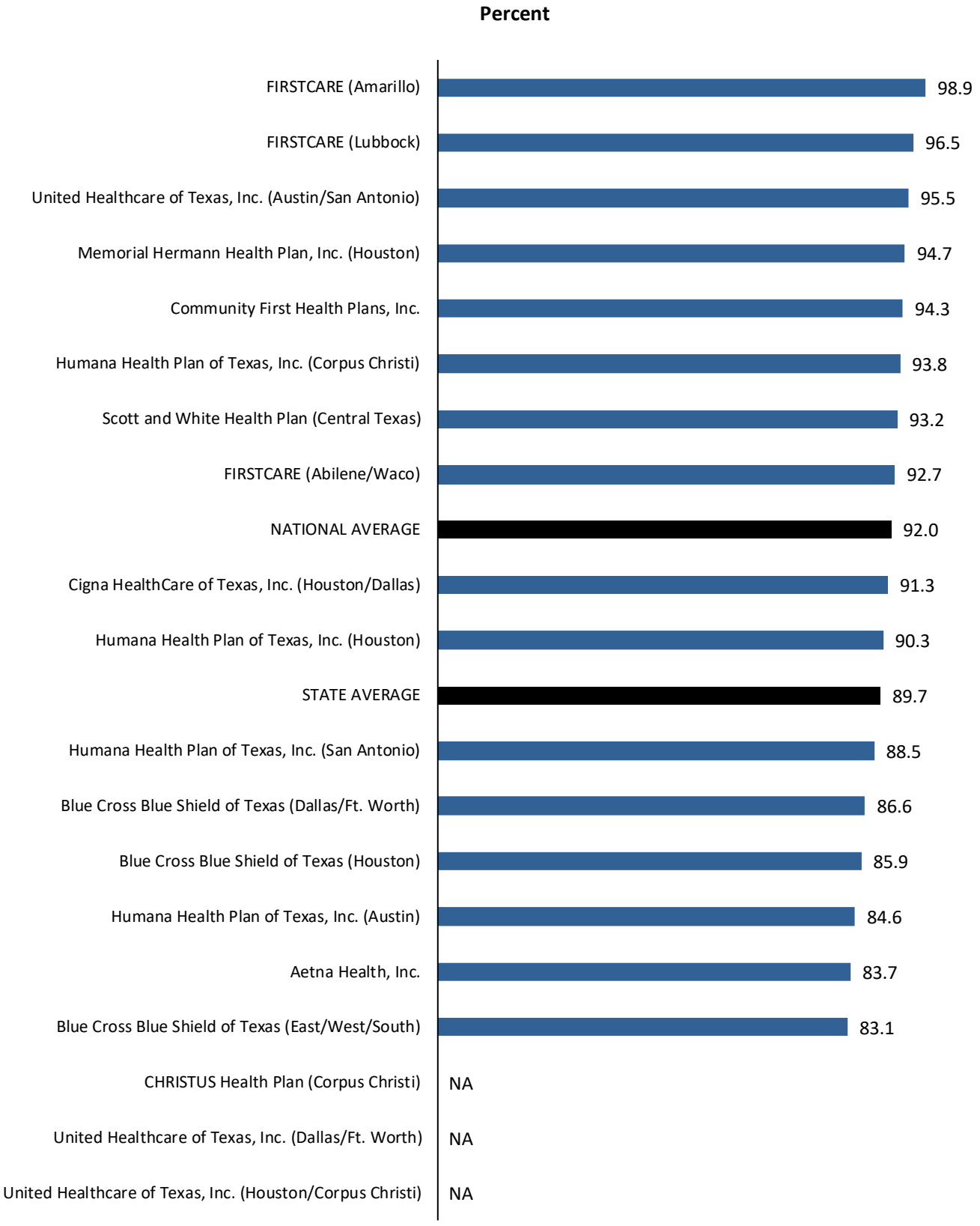
[1] Hamborsky, Jennifer, Andrew Kroger, and Charles Wolfe, eds. Centers for Disease Control and Prevention. *Epidemiology and Prevention of Vaccine-Preventable Diseases*. 13th ed. Washington, D.C.: Public Health Foundation, 2015.

VZV



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Childhood Immunization Status: Pneumococcal Conjugate

DEFINITION:

The percentage of children using the HMO who received 4 doses of the Pneumococcal Conjugate vaccine by the age of 2.

Pneumococcal disease is a bacterial infection caused by *Streptococcus pneumonia*. The disease can present itself in several ways including pneumococcal pneumonia (a lung infection), bacteremia (a blood stream infection), meningitis (an infection of the covering of the brain), and otitis media (a middle ear infection). Complications can include brain damage, hearing loss, and death. Pneumococcal disease is the leading cause of meningitis in the U.S.

Pneumococcal Conjugate					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	74.9%	76.5%	75.9%	77.7%	74.3%
NCQA's Quality Compass®	85.9%	85.4%	85.7%	86.1%	85.5%

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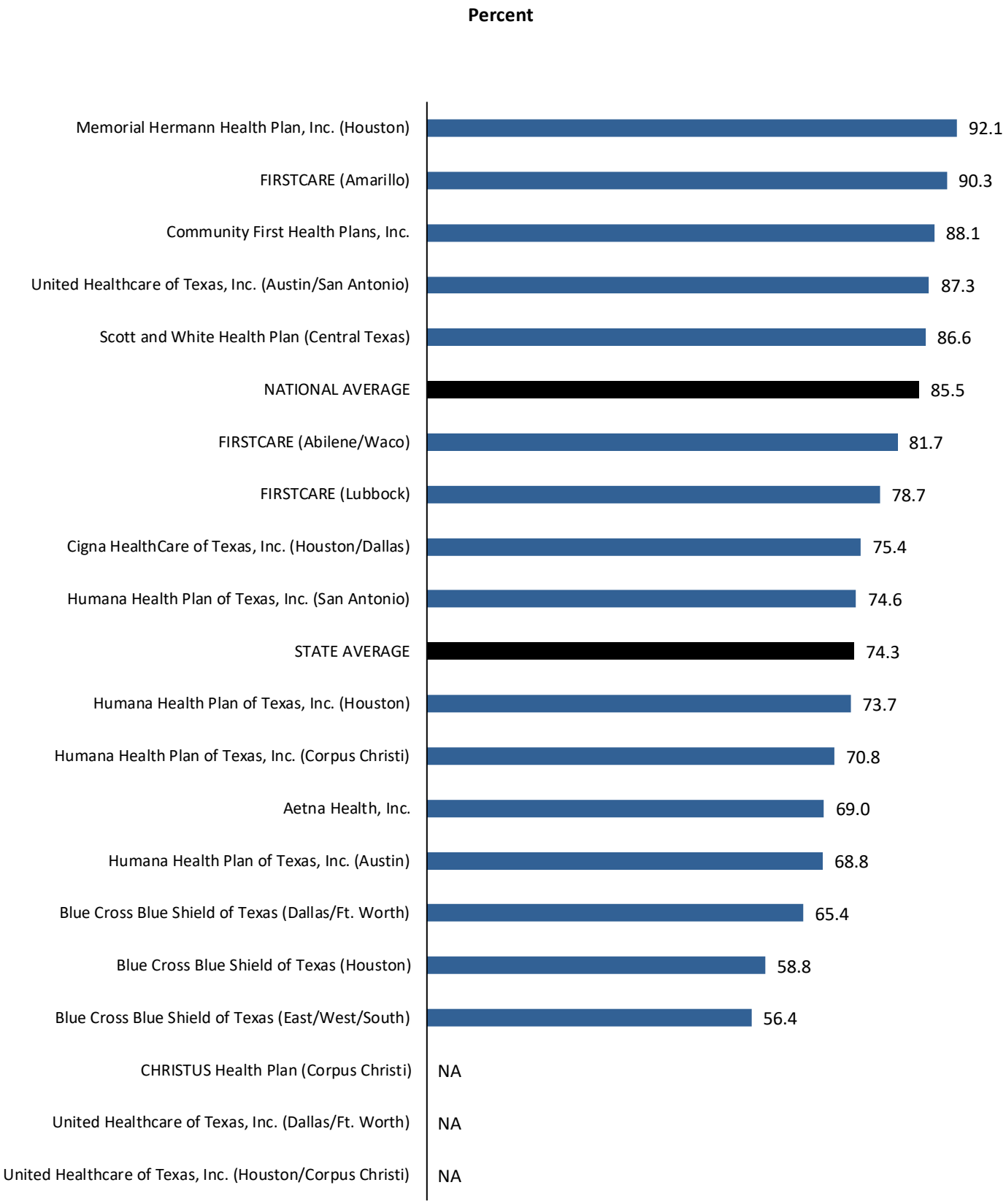
Pneumococcal Conjugate



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Childhood Immunization Status: Hepatitis A (HAV)

DEFINITION:

The percentage of children using the HMO who received 1 dose of the Hepatitis A (HAV) vaccine by the age of 2.

HAV is a contagious viral disease that affects the liver. Symptoms include jaundice (yellow coloration of the skin and eyes), fever, and nausea. The disease typically spreads through contact with objects, food, or drinks contaminated with the stool of an infected person. It can range in severity from a mild illness lasting a few weeks to a severe illness lasting several months. Unlike Hepatitis B and C, HAV is not a chronic illness.[1]

HAV					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	90.4%	90.2%	91.7%	90.9%	90.1%
NCQA's Quality Compass®	85.5%	86.8%	87.8%	88.2%	89.1%

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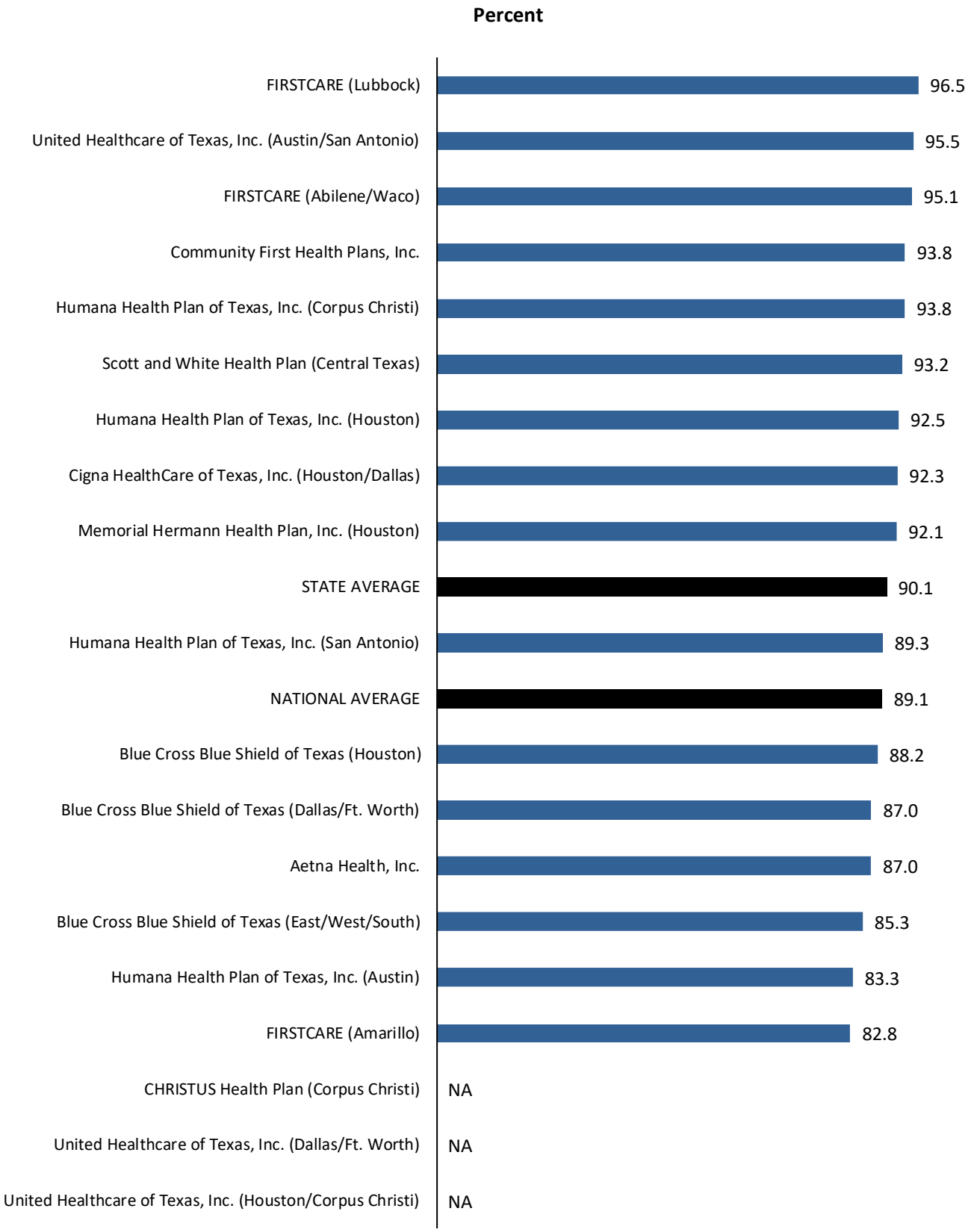
HAV



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Childhood Immunization Status:
Rotavirus

DEFINITION:

The percentage of children using the HMO who received the required doses of the Rotavirus vaccine. There is a 2 dose and a 3 dose schedule.

Rotavirus causes gastroenteritis (inflammation of the stomach and intestines). Symptoms include severe watery diarrhea, often accompanied by vomiting, fever, and abdominal pain. In babies and young children, the virus can lead to life-threatening dehydration.

Rotavirus is the leading cause of severe diarrhea in infants and young children worldwide. Rotavirus was the leading cause of severe diarrhea in American infants and young children before the introduction of the vaccine in 2006.[1]

Rotavirus					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	74.6%	73.6%	73.1%	75.8%	71.4%
NCQA's Quality Compass®	80.2%	80.6%	81.8%	82.9%	83.3%

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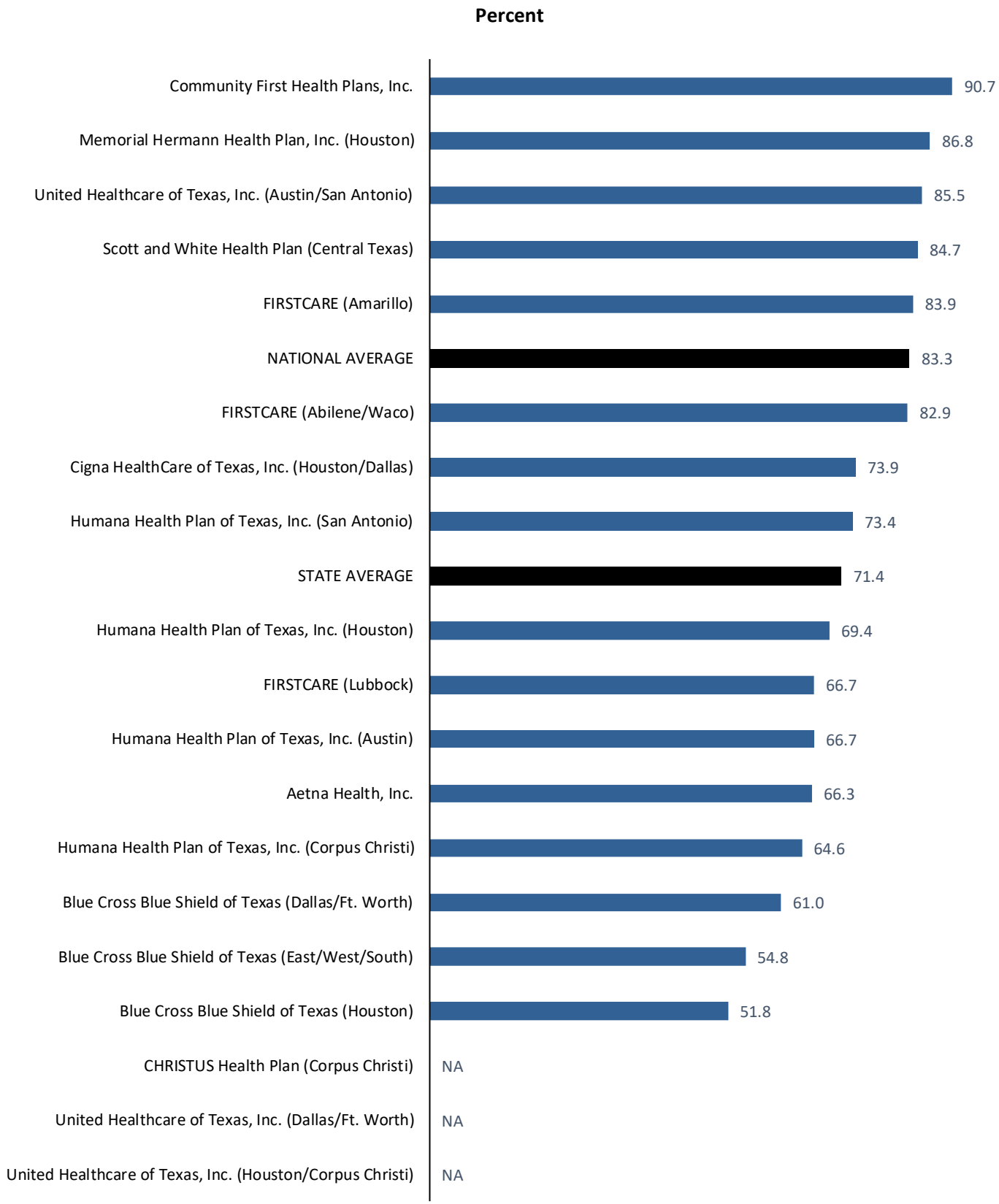
[1] Hamborsky, Jennifer, Andrew Kroger, and Charles Wolfe, eds. Centers for Disease Control and Prevention. *Epidemiology and Prevention of Vaccine-Preventable Diseases*. 13th ed. Washington, D.C.: Public Health Foundation, 2015.

Rotavirus



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Childhood Immunization Status: Influenza

DEFINITION:

The percentage of children using the HMO who received 2 doses of the Influenza vaccine by the age of 2.

The **flu** is a highly contagious viral illness. Symptoms can include fever, sore throat, headache, cough, and sore muscles. Complications can include pneumonia (a lung infection), myocarditis (inflammation of the heart), and death. Young children, adults over 65, and individuals with underlying medical conditions have the highest risk of complications and death from the flu. On average, more than 200,000 people are hospitalized per year for influenza related symptoms.[1]

The Advisory Committee on Immunization Practices (ACIP) recommends yearly influenza vaccinations for all individuals over 6 months, but emphasizes the importance of yearly vaccinations in vulnerable populations.[2]

Influenza					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	60.8%	62.8%	61.7%	61.6%	63.7%
NCQA's Quality Compass®	64.8%	64.5%	66.1%	67.3%	69.8%

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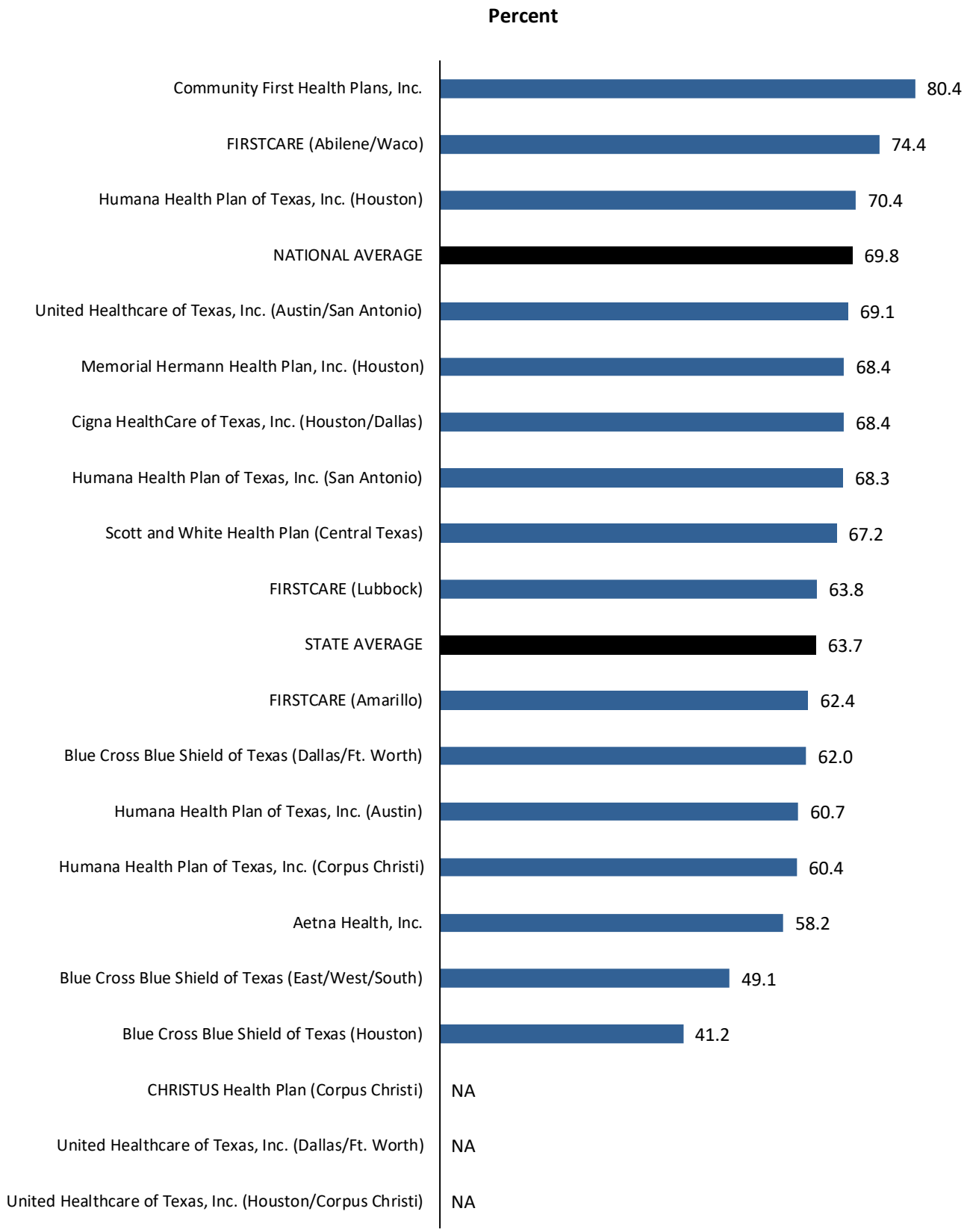
[1] Hamborsky, Jennifer, Andrew Kroger, and Charles Wolfe, eds. Centers for Disease Control and Prevention. *Epidemiology and Prevention of Vaccine-Preventable Diseases*. 13th ed. Washington, D.C.: Public Health Foundation, 2015.
[2] Ibid.

Influenza



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Childhood Immunization Status: Combination 2

DEFINITION:

The percentage of children using the HMO who received all doses of the Combination 2 vaccinations by the age of 2.

Combination 2 includes:

- Diphtheria, Tetanus, acellular Pertussis (DTaP) - 4 doses
- Polio (IPV) - 3 doses
- Hepatitis B (HBV) - 3 doses
- Measles, Mumps, Rubella (MMR) - 1 dose
- *Haemophilus Influenzae* type B (HiB) - 3 doses
- Chickenpox (VZV) - 1 dose

Combination 2					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	66.7%	56.4%	61.0%	67.5%	53.0%
NCQA's Quality Compass®	78.4%	78.5%	78.6%	79.5%	79.7%

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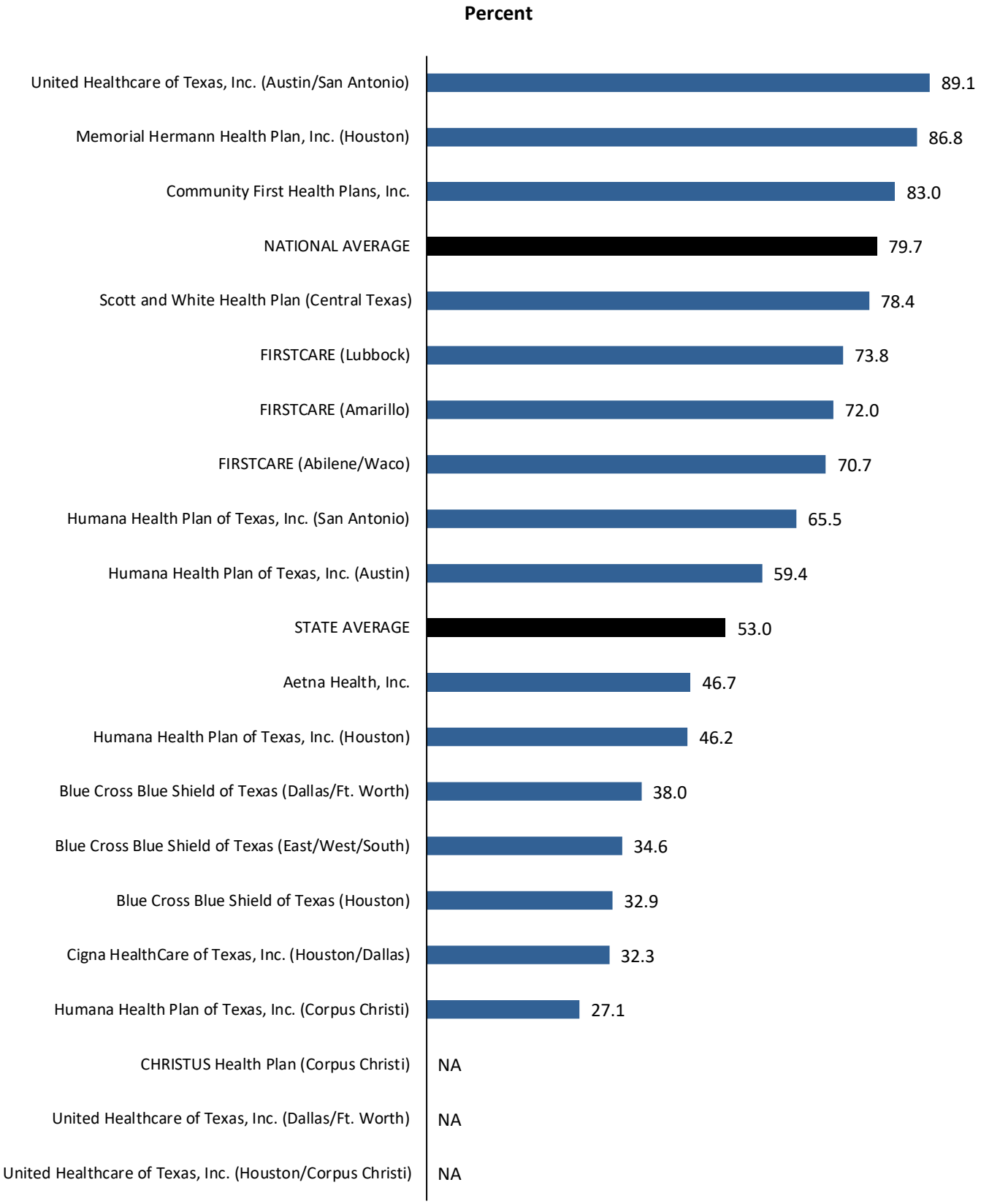
Combination 2



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Childhood Immunization Status: Combination 3

DEFINITION:

The percentage of children using the HMO who received all doses of the Combination 3 vaccinations by the age of 2.

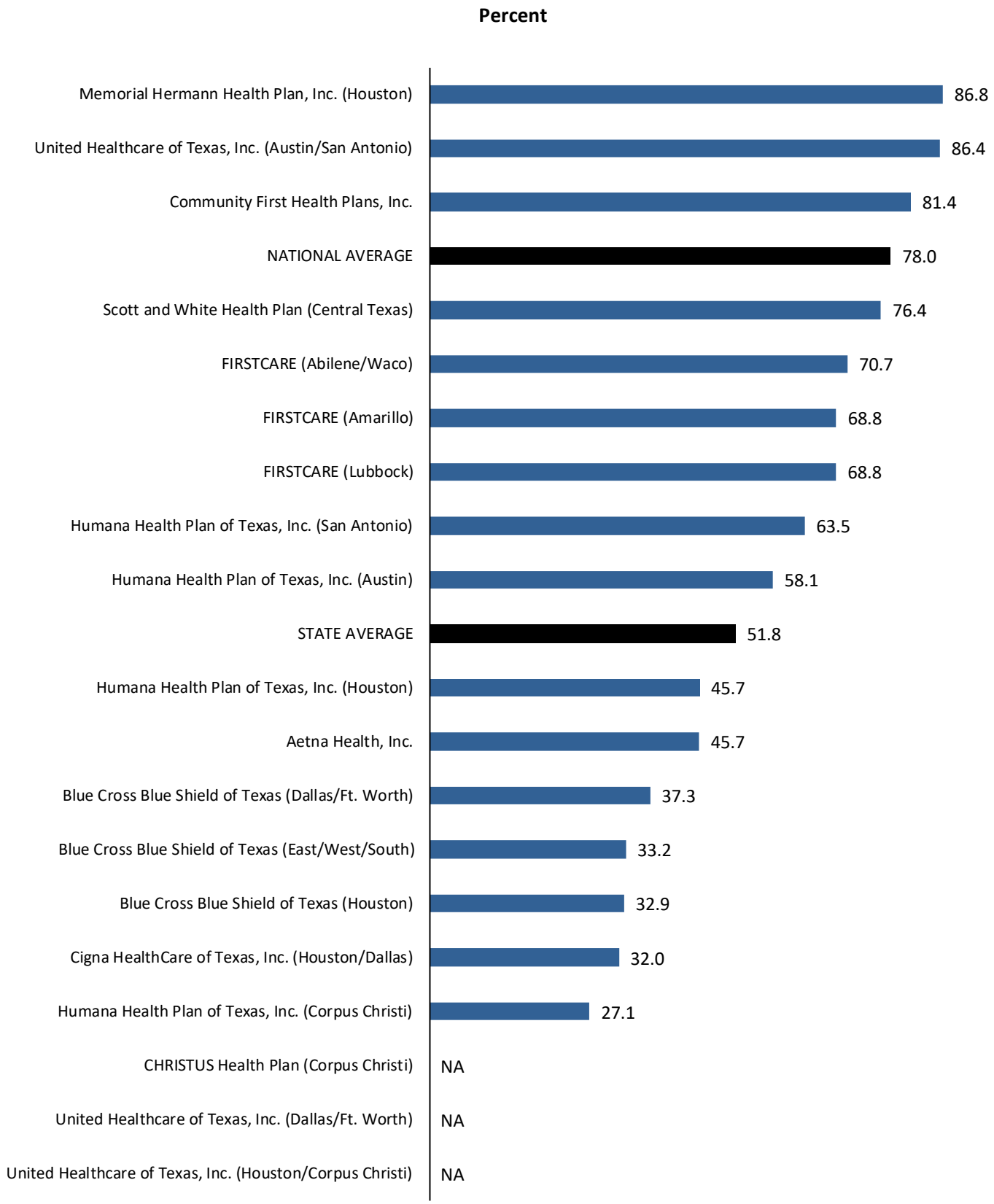
Combination 3 includes:

- Diphtheria, Tetanus, acellular Pertussis (DTaP) - 4 doses
- Polio (IPV) - 3 doses
- Hepatitis B (HBV) - 3 doses
- Measles, Mumps, Rubella (MMR) - 1 dose
- *Haemophilus Influenzae* type B (HiB) - 3 doses
- Chickenpox (VZV) - 1 dose
- Pneumococcal Conjugate - 4 doses

Combination 3					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	64.0%	55.1%	58.5%	64.7%	51.8%
NCQA's Quality Compass®	76.3%	76.5%	76.9%	77.7%	78.0%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

Combination 3



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Childhood Immunization Status: Combination 4

DEFINITION:

The percentage of children using the HMO who received all doses of the Combination 4 vaccinations by the age of 2.

Combination 4 includes:

- Diphtheria, Tetanus, acellular Pertussis (DTaP) - 4 doses
- Polio (IPV) - 3 doses
- Hepatitis B (HBV) - 3 doses
- Measles, Mumps, Rubella (MMR) - 1 dose
- *Haemophilus Influenzae* type B (HiB) - 3 doses
- Chickenpox (VZV) - 1 dose
- Pneumococcal Conjugate - 4 doses
- Hepatitis A (HAV) - 1 dose

Combination 4					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	62.8%	54.8%	57.6%	63.8%	51.1%
NCQA's Quality Compass®	71.8%	72.8%	73.7%	75.0%	75.9%

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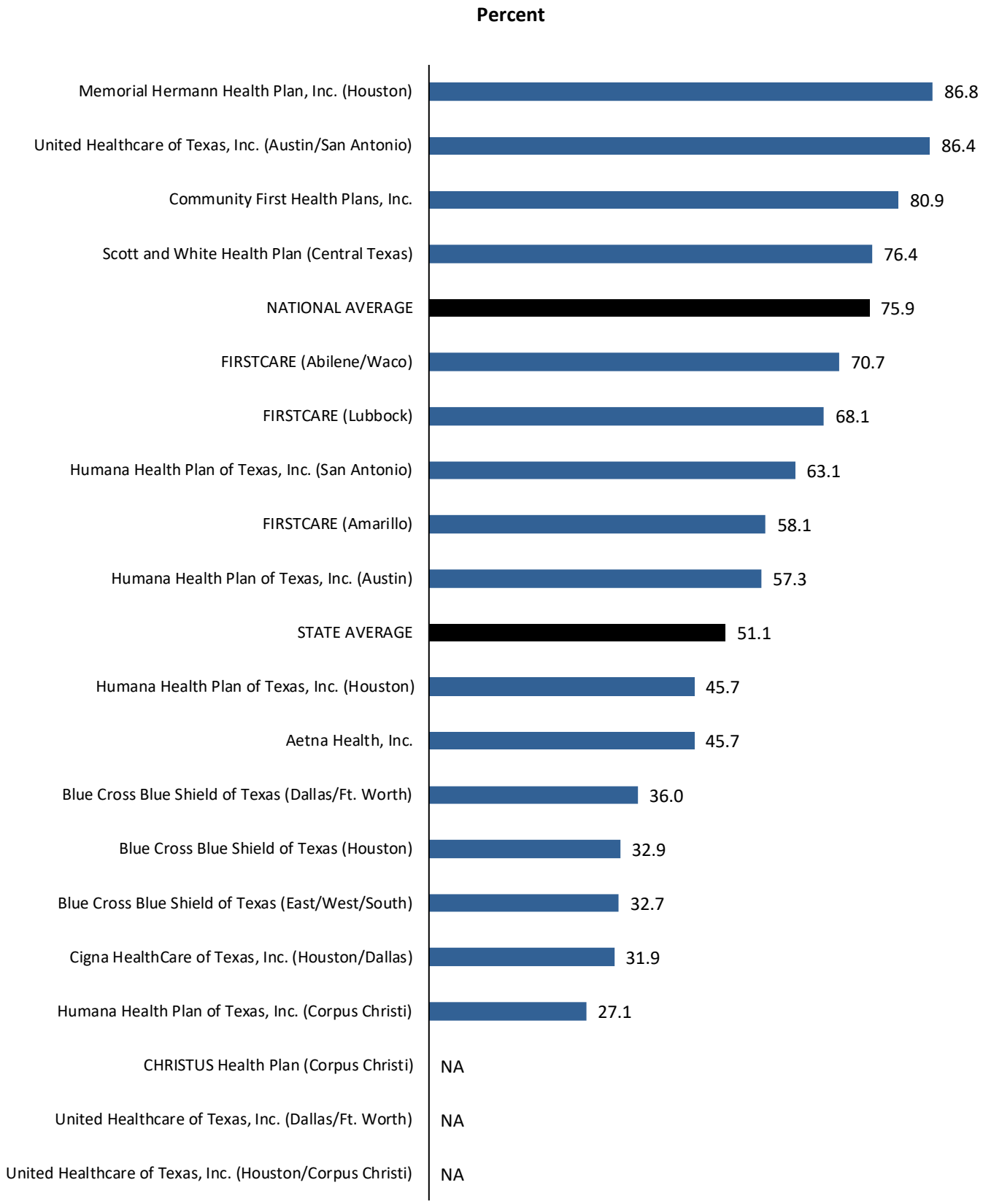
Combination 4



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Childhood Immunization Status: Combination 5

DEFINITION:

The percentage of children using the HMO who received all doses of the Combination 5 vaccinations by the age of 2.

Combination 5 includes:

- Diphtheria, Tetanus, acellular Pertussis (DTaP) - 4 doses
- Polio (IPV) - 3 doses
- Hepatitis B (HBV) - 3 doses
- Measles, Mumps, Rubella (MMR) - 1 dose
- *Haemophilus Influenzae* type B (HiB) - 3 doses
- Chickenpox (VZV) - 1 dose
- Pneumococcal Conjugate - 4 doses
- Rotavirus - 2 or 3 doses

Combination 5					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	58.8%	50.9%	54.1%	59.5%	48.4%
NCQA's Quality Compass®	69.5%	70.2%	71.1%	72.6%	73.3%

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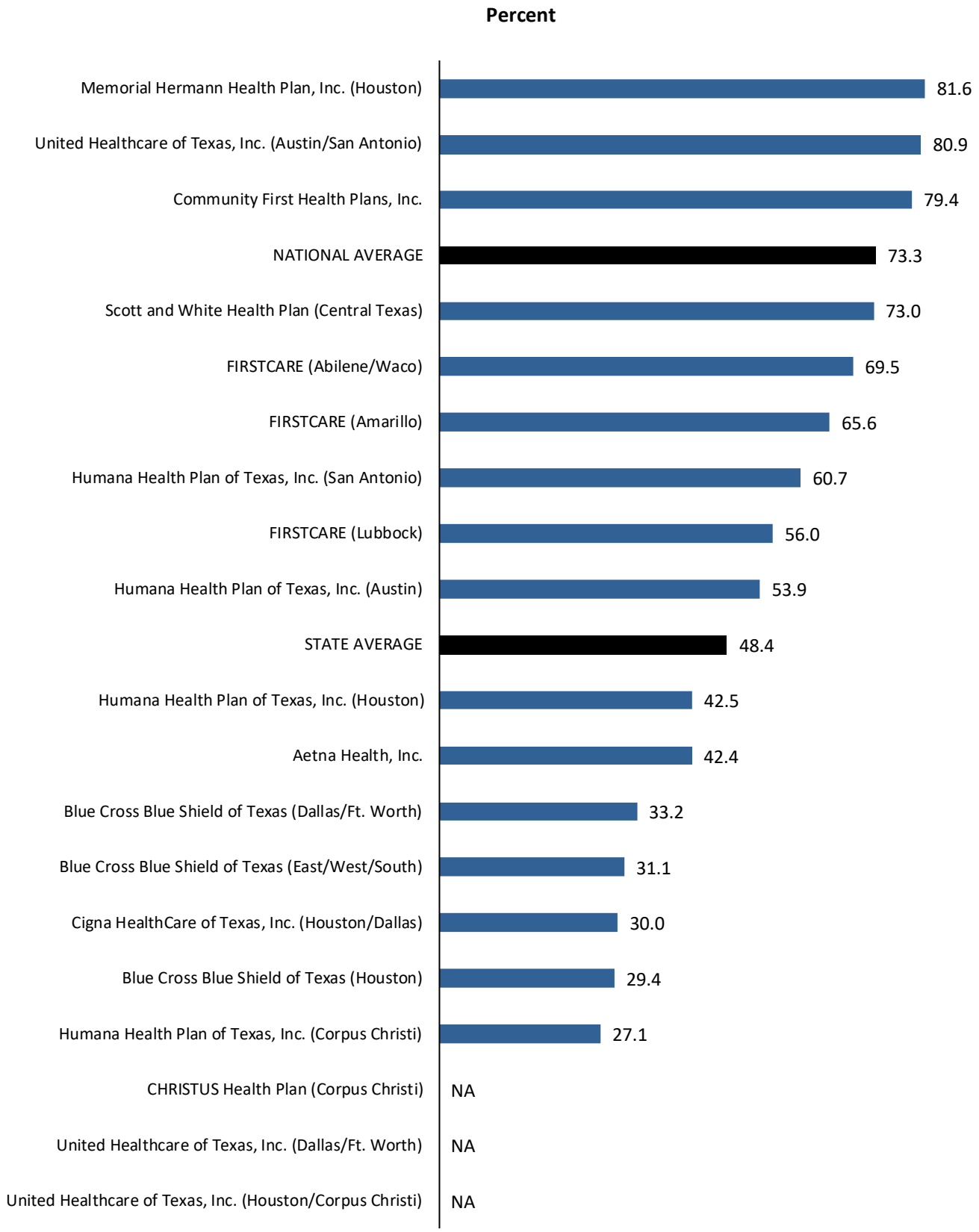
Combination 5



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Childhood Immunization Status: Combination 6

DEFINITION:

The percentage of children using the HMO who received all doses of the Combination 6 vaccinations by the age of 2.

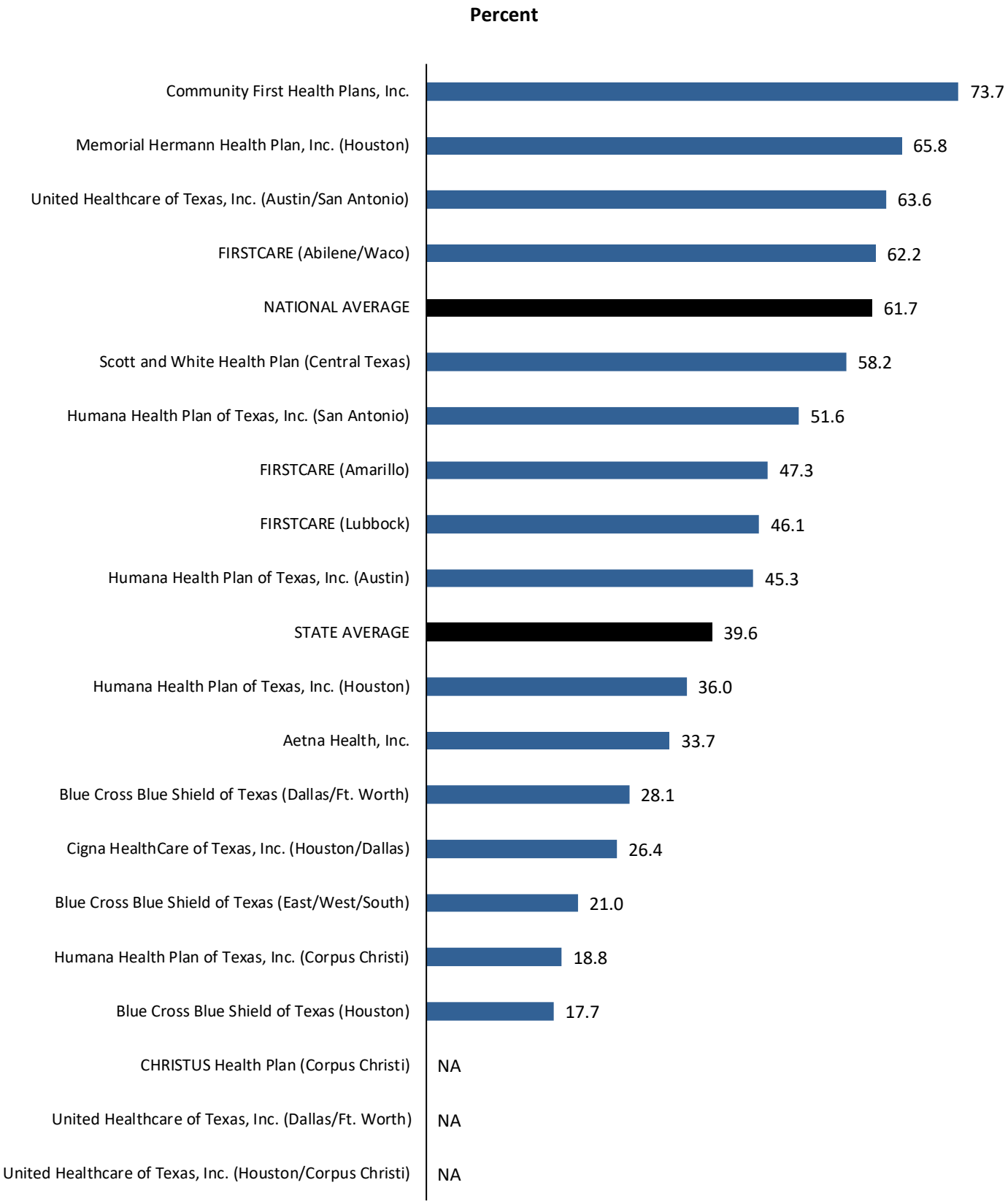
Combination 6 includes:

- Diphtheria, Tetanus, acellular Pertussis (DTaP) - 4 doses
- Polio (IPV) - 3 doses
- Hepatitis B (HBV) - 3 doses
- Measles, Mumps, Rubella (MMR) - 1 dose
- *Haemophilus Influenzae* type B (HiB) - 3 doses
- Chickenpox (VZV) - 1 dose
- Pneumococcal Conjugate - 4 doses
- Influenza - 2 doses

Combination 6					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	45.1%	41.1%	42.7%	47.1%	39.6%
NCQA's Quality Compass®	56.6%	56.6%	58.0%	59.5%	61.7%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

Combination 6



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Childhood Immunization Status: Combination 7

DEFINITION:

The percentage of children using the HMO who received all doses of the Combination 7 vaccinations by the age of 2.

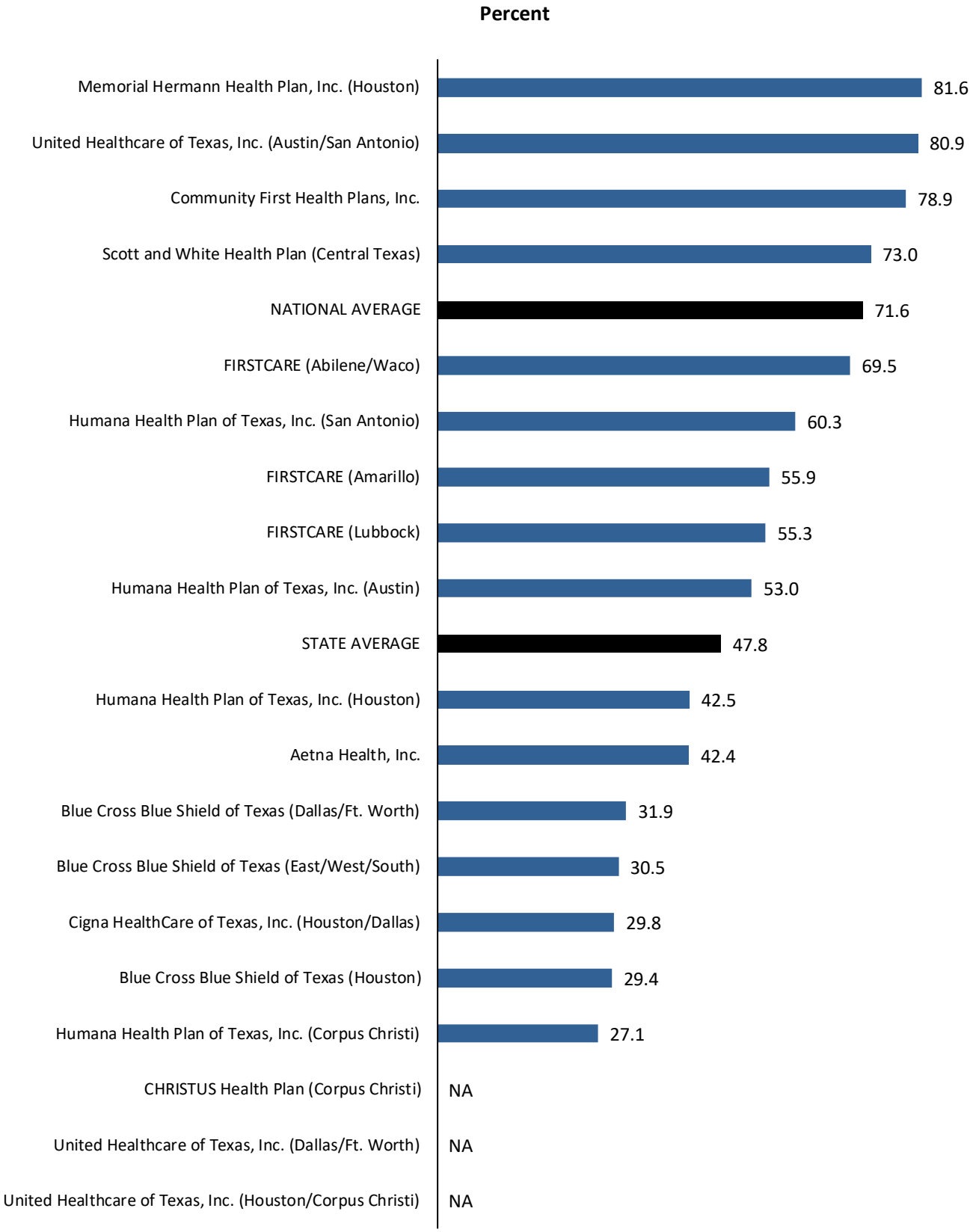
Combination 7 includes:

- Diphtheria, Tetanus, acellular Pertussis (DTaP) - 4 doses
- Polio (IPV) - 3 doses
- Hepatitis B (HBV) - 3 doses
- Measles, Mumps, Rubella (MMR) - 1 dose
- *Haemophilus Influenzae* type B (HiB) - 3 doses
- Chickenpox (VZV) - 1 dose
- Pneumococcal Conjugate - 4 doses
- Hepatitis A (HAV) - 1 dose
- Rotavirus - 2 or 3 doses

Combination 7					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	58.0%	50.3%	53.3%	58.7%	47.8%
NCQA's Quality Compass®	66.2%	67.4%	68.7%	70.6%	71.6%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

Combination 7



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Childhood Immunization Status: Combination 8

DEFINITION:

The percentage of children using the HMO who received all doses of the Combination 8 vaccinations by the age of 2.

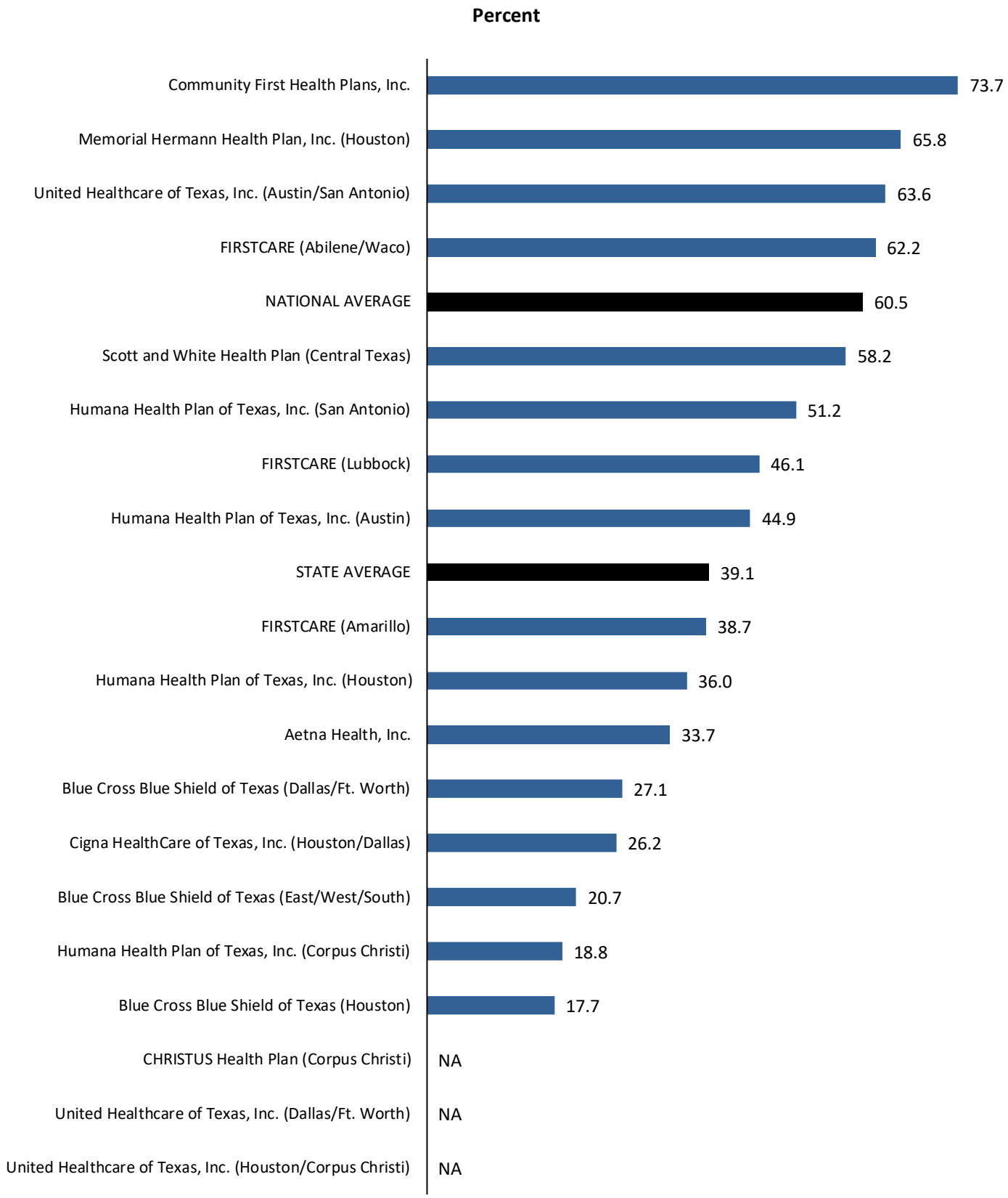
Combination 8 includes:

- Diphtheria, Tetanus, acellular Pertussis (DTaP) - 4 doses
- Polio (IPV) - 3 doses
- Hepatitis B (HBV) - 3 doses
- Measles, Mumps, Rubella (MMR) - 1 dose
- *Haemophilus Influenzae* type B (HiB) - 3 doses
- Chickenpox (VZV) - 1 dose
- Pneumococcal Conjugate - 4 doses
- Hepatitis A (HAV) - 1 dose
- Influenza - 2 doses

Combination 8					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	44.3%	41.0%	42.3%	46.5%	39.1%
NCQA's Quality Compass®	54.1%	54.6%	56.4%	58.0%	60.5%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

Combination 8



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Childhood Immunization Status: Combination 9

DEFINITION:

The percentage of children using the HMO who received all doses of the Combination 9 vaccinations by the age of 2.

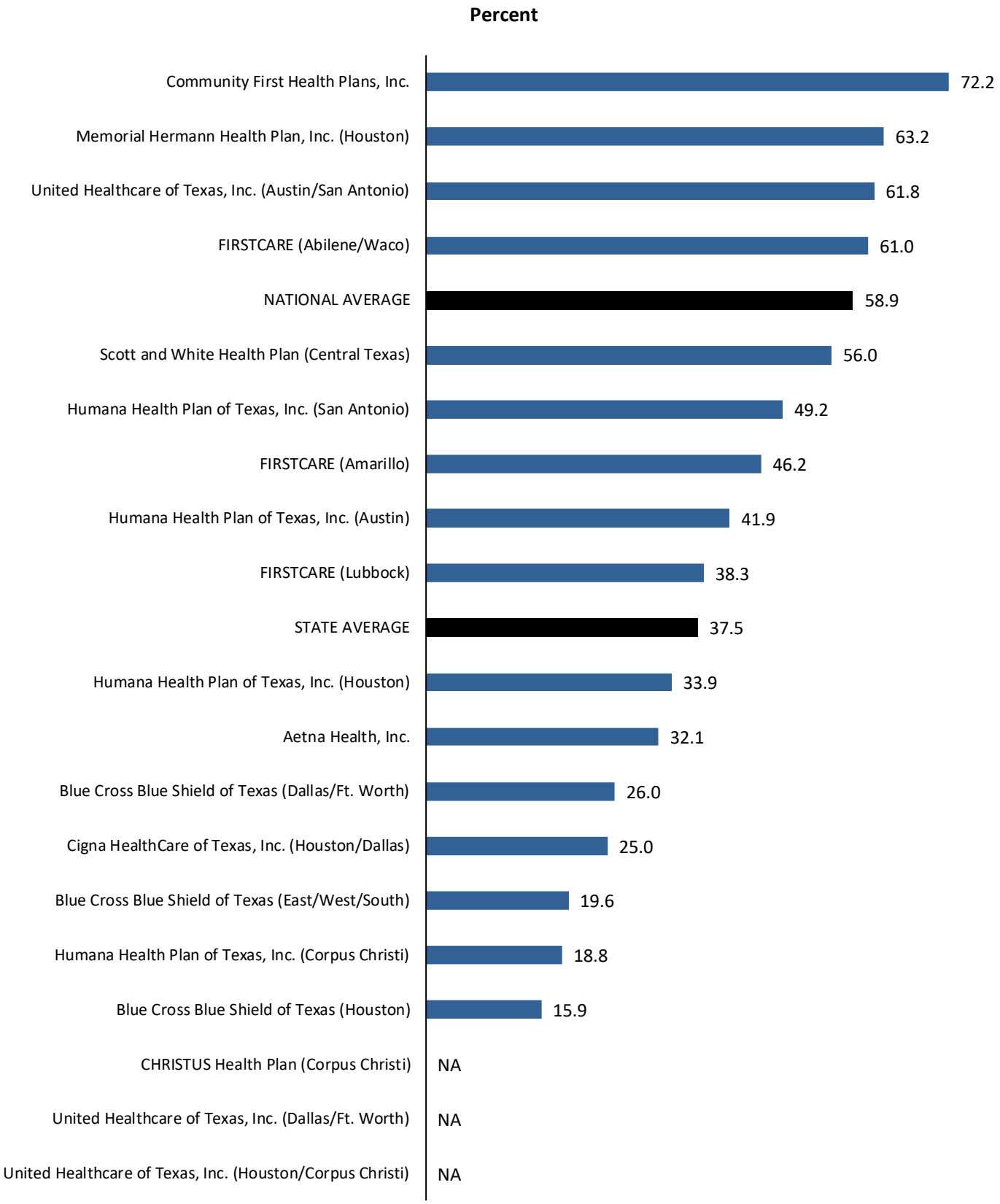
Combination 9 includes:

- Diphtheria, Tetanus, acellular Pertussis (DTaP) - 4 doses
- Polio (IPV) - 3 doses
- Hepatitis B (HBV) - 3 doses
- Measles, Mumps, Rubella (MMR) - 1 dose
- *Haemophilus Influenzae* type B (HiB) - 3 doses
- Chickenpox (VZV) - 1 dose
- Pneumococcal Conjugate - 4 doses
- Influenza - 2 doses
- Rotavirus - 2 or 3 doses

Combination 9					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	42.4%	38.9%	40.3%	44.2%	37.5%
NCQA's Quality Compass®	53.0%	53.2%	54.7%	56.6%	58.9%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

Combination 9



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Childhood Immunization Status: Combination 10

DEFINITION:

The percentage of children using the HMO who received all doses of the Combination 10 vaccinations by the age of 2.

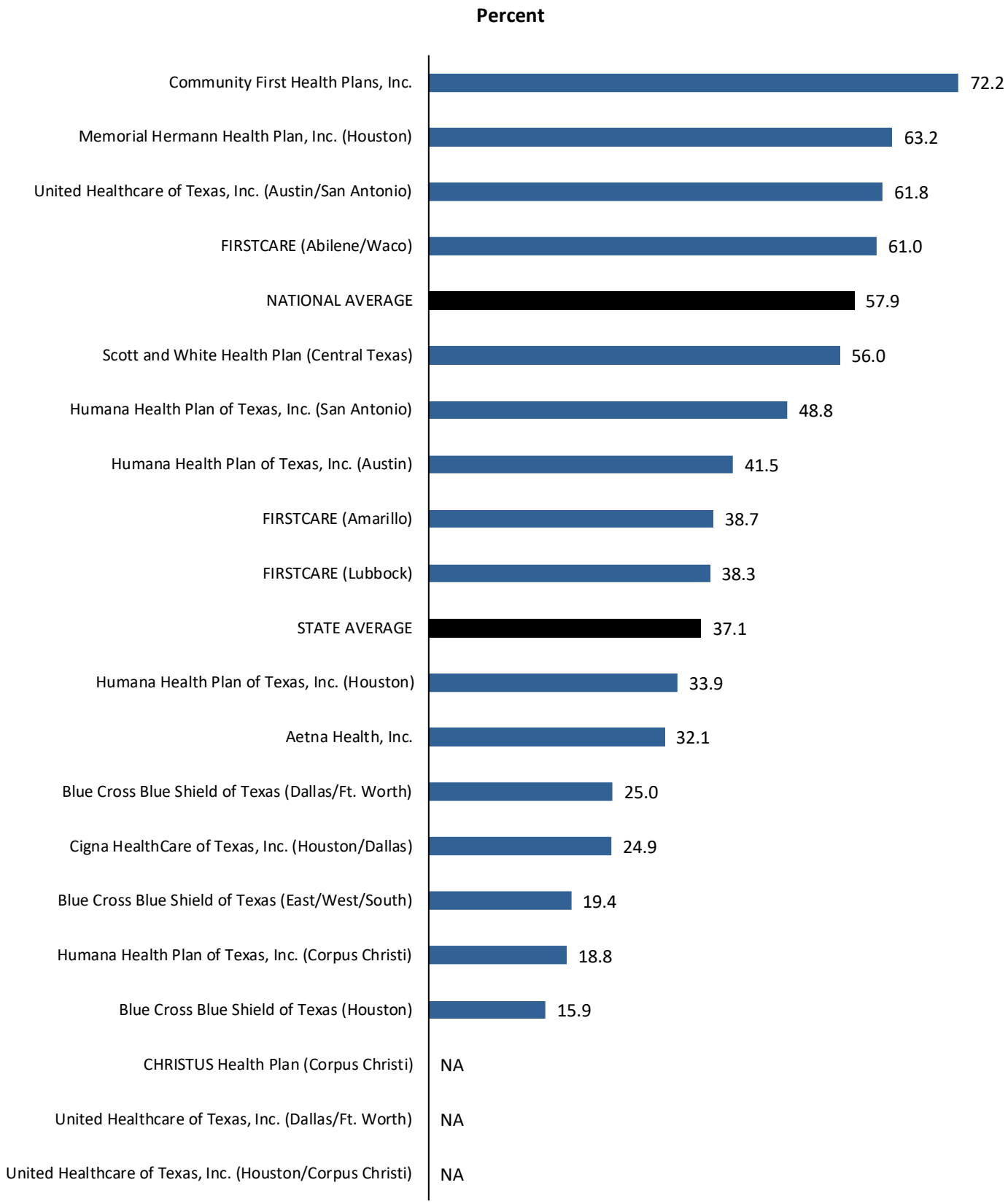
Combination 10 includes:

- Diphtheria, Tetanus, acellular Pertussis (DTaP) - 4 doses
- Polio (IPV) - 3 doses
- Hepatitis B (HBV) - 3 doses
- Measles, Mumps, Rubella (MMR) - 1 dose
- *Haemophilus Influenzae* type B (HiB) - 3 doses
- Chickenpox (VZV) - 1 dose
- Pneumococcal Conjugate - 4 doses
- Hepatitis A (HAV) - 1 dose
- Rotavirus - 2 or 3 doses
- Influenza - 2 doses

Combination 10					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	42.0%	38.5%	40.3%	43.6%	37.1%
NCQA's Quality Compass®	51.0%	51.0%	53.4%	55.4%	57.9%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

Combination 10



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Breast Cancer Screening

DEFINITION:

The percentage of women 50-74 years of age who received a mammogram to screen for breast cancer.

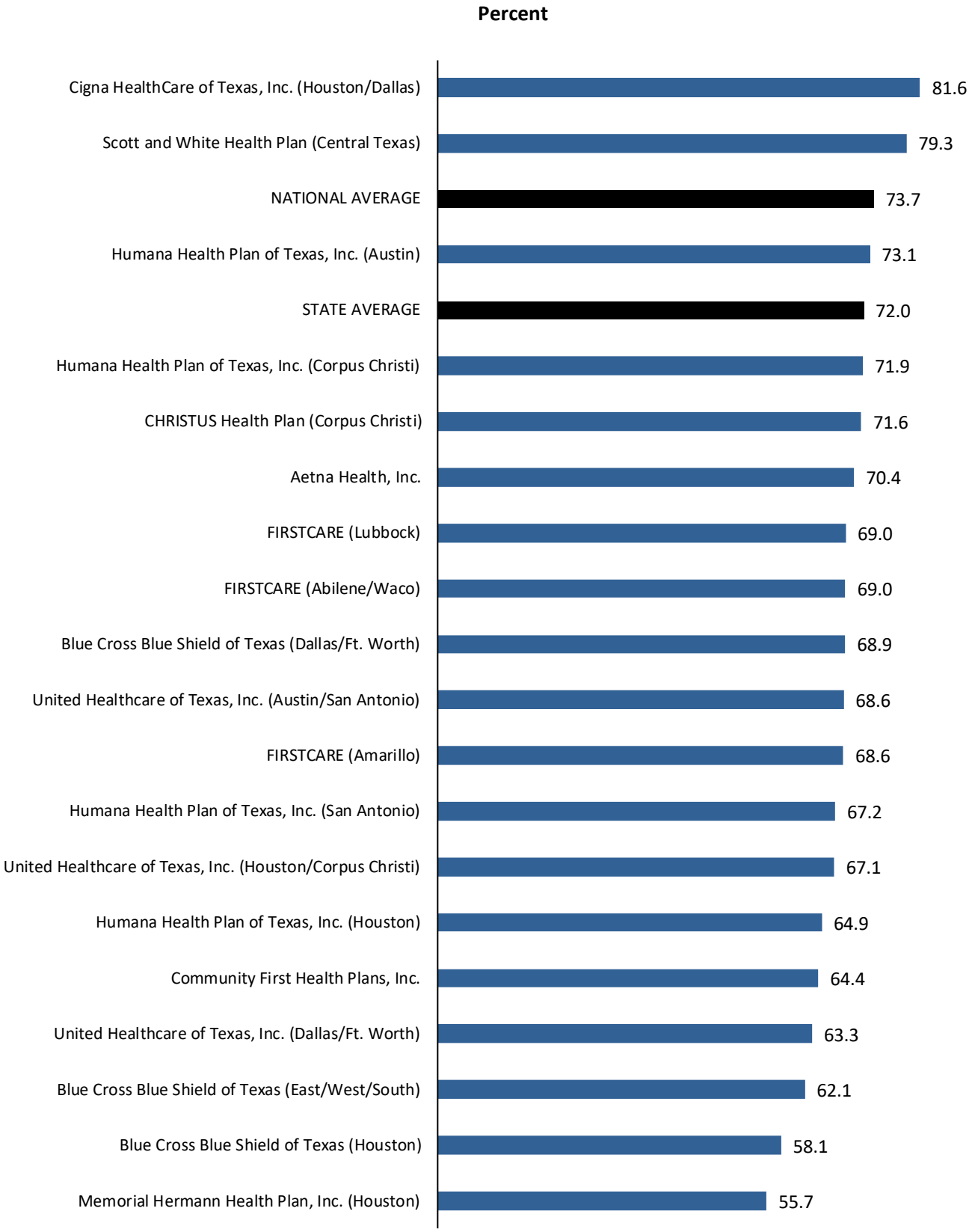
A **mammogram**, an x-ray of the tissues inside the breast, can detect breast cancer before a woman has signs or symptoms of the disease. Early detection of breast cancer often leads to a greater range of treatment options, including less-invasive options. A mammogram will not detect all breast cancers, and some breast cancers may still have poor prognosis. However, regular mammograms in women over the age of 40 can reduce the risk of a woman dying from breast cancer.[1]

Breast Cancer Screening					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	71.5%	72.2%	69.1%	71.3%	72.0%
NCQA's Quality Compass®	73.2%	72.7%	72.7%	73.5%	73.7%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

[1] American Cancer Society. *Breast Cancer Facts and Figures 2015-2016*. Atlanta, GA: American Cancer Society, 2015.

Breast Cancer Screening Rate



Cervical Cancer Screening

DEFINITION:

The percentage of women 21-64 years of age who received 1 or more Pap tests to screen for cervical cancer during the previous 3 years.

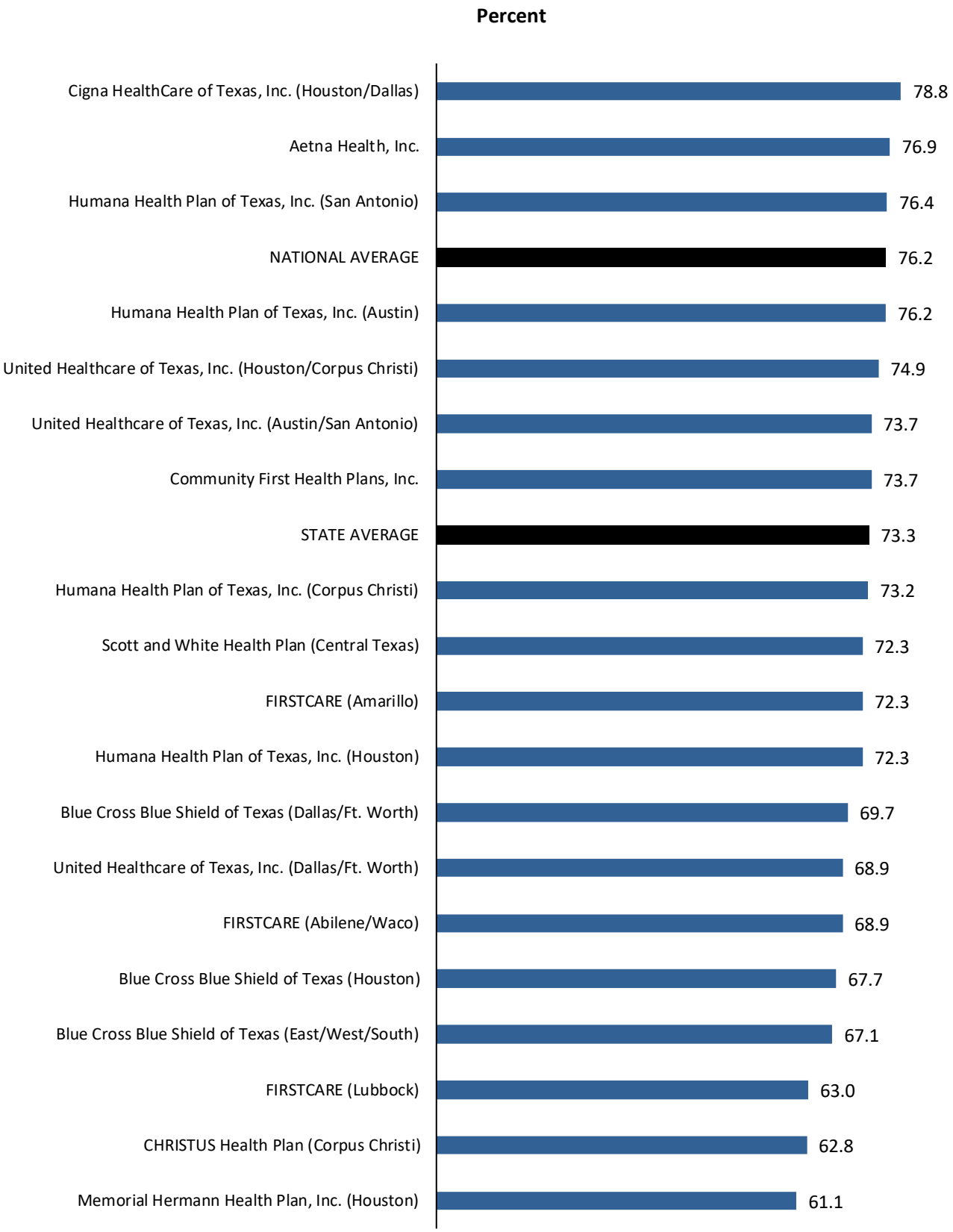
Cervical cancer often has no recognizable symptoms until it reaches an advanced stage. Regular Pap tests can detect cervical cancer before symptoms are present. A Pap test uses cells collected from the cervix to detect cancerous and precancerous cells. The test can also detect noncancerous conditions such as infection and inflammation.[1] Early detection and treatment of cancer through Pap screening has reduced the rate of deaths from cervical cancer by 50%.[2] The American College of Obstetricians and Gynecologists (ACOG)[3] and the American Cancer Society (ACS)[4] recommend Pap testing every 3 years for women 21-65.

Cervical Cancer Screening					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	73.9%	74.4%	72.5%	73.2%	73.3%
NCQA's Quality Compass®	74.7%	74.3%	74.3%	75.2%	76.2%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

[1] National Cancer Institute. *Pap and HPV Testing Fact Sheet*. Washington, D.C.: National Institutes of Health, 2016.
[2] National Cancer Institute. *A Snapshot of Cervical Cancer*. Washington, D.C.: National Institutes of Health, 2014.
[3] American College of Obstetricians and Gynecologists. *Cervical Cancer Screening*. Washington, D.C.: American College of Obstetricians and Gynecologists, 2016.
[4] Saslow, Debbie. "Screening Guidelines for the Prevention and Early Detection of Cervical Cancer." CA: *A Cancer Journal for Clinicians*. Atlanta, GA: American Cancer Society, 2012.

Cervical Cancer Screening Rate



Non-Recommended Cervical Cancer Screening in Adolescent Females

DEFINITION:

The percentage of young women 16-20 years of age who were unnecessarily screened for cervical cancer.

The American College of Obstetricians and Gynecologists (ACOG)[1] and the American Cancer Society (ACS)[2] recommend against cervical cancer screening for women under 21 years of age.

**Note: Lower rates indicate better performance for this measure.*

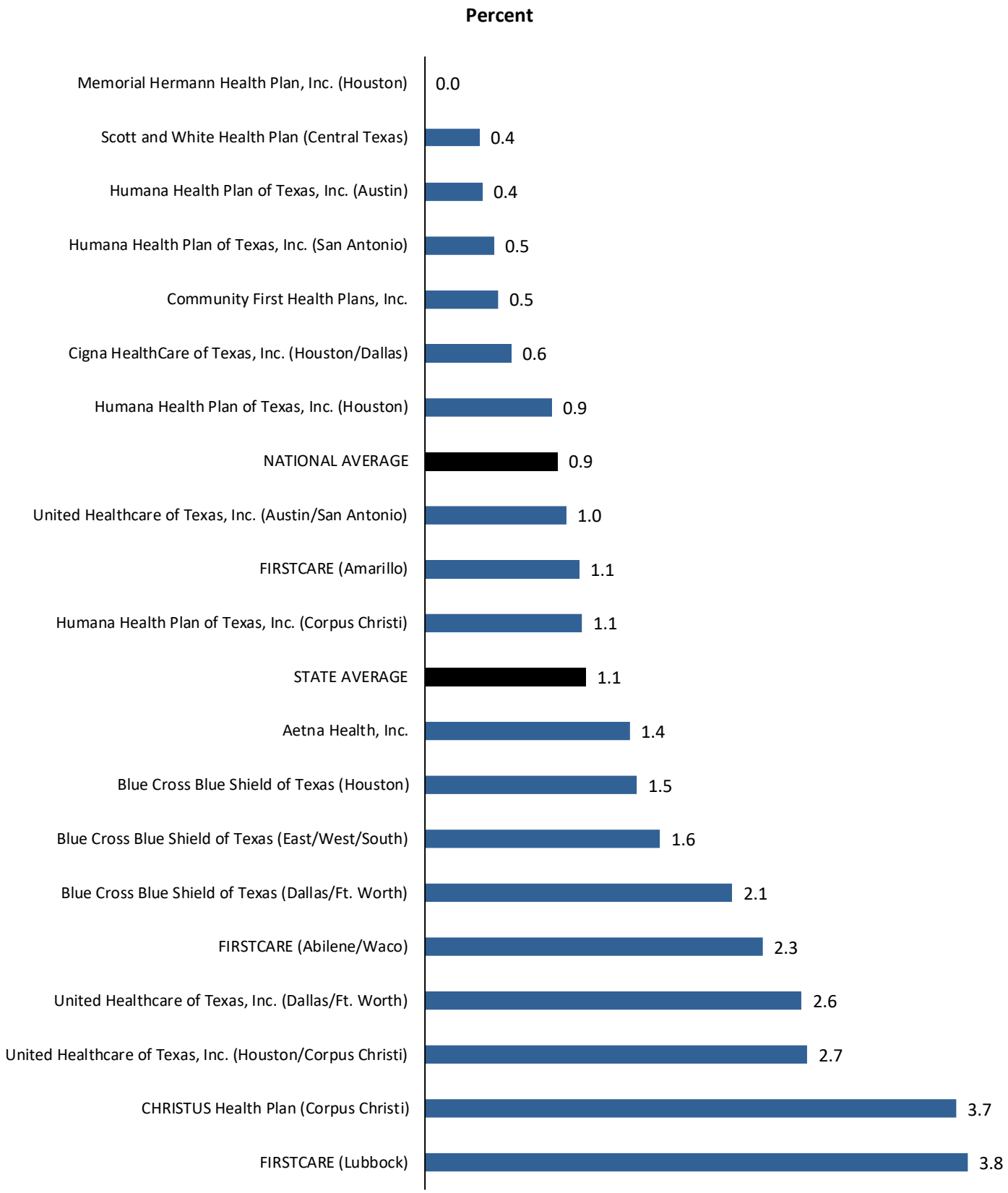
Non-Recommended Cervical Cancer Screening in Adolescent Females					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	2.7%	2.1%	2.0%	1.6%	1.1%
NCQA's Quality Compass®	2.3%	1.8%	1.5%	1.1%	0.9%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

[1] American College of Obstetricians and Gynecologists. *Cervical Cancer Screening*. Washington, D.C.: American College of Obstetricians and Gynecologists, 2016.

[2] Saslow, Debbie. "Screening Guidelines for the Prevention and Early Detection of Cervical Cancer." CA: *A Cancer Journal for Clinicians*. Atlanta, GA: American Cancer Society, 2012.

Non-Recommended Cervical Cancer Screening Rate



**Note: Lower rates indicate better performance for this measure.*

Colorectal Cancer Screening

DEFINITION:

The percentage of adult members 50-75 years of age who had an appropriate screening for colorectal cancer.

Colorectal cancer (CRC) is the third leading cause of cancer-related deaths in the U.S. CRC typically develops from a noncancerous polyp and grows slowly over a period of 10-15 years. Systematic screening can identify polyps before cancer develops or detect cancer in its early stages when treatment is most effective and least invasive.[1]

The incidence of CRC increases with age. Approximately 90% of new cases occur in adults over the age of 50.[2] This measure reports the percentage of adults 50-75 years of age who have received an appropriate screening for CRC. "Appropriate screening" is defined as one of the following:

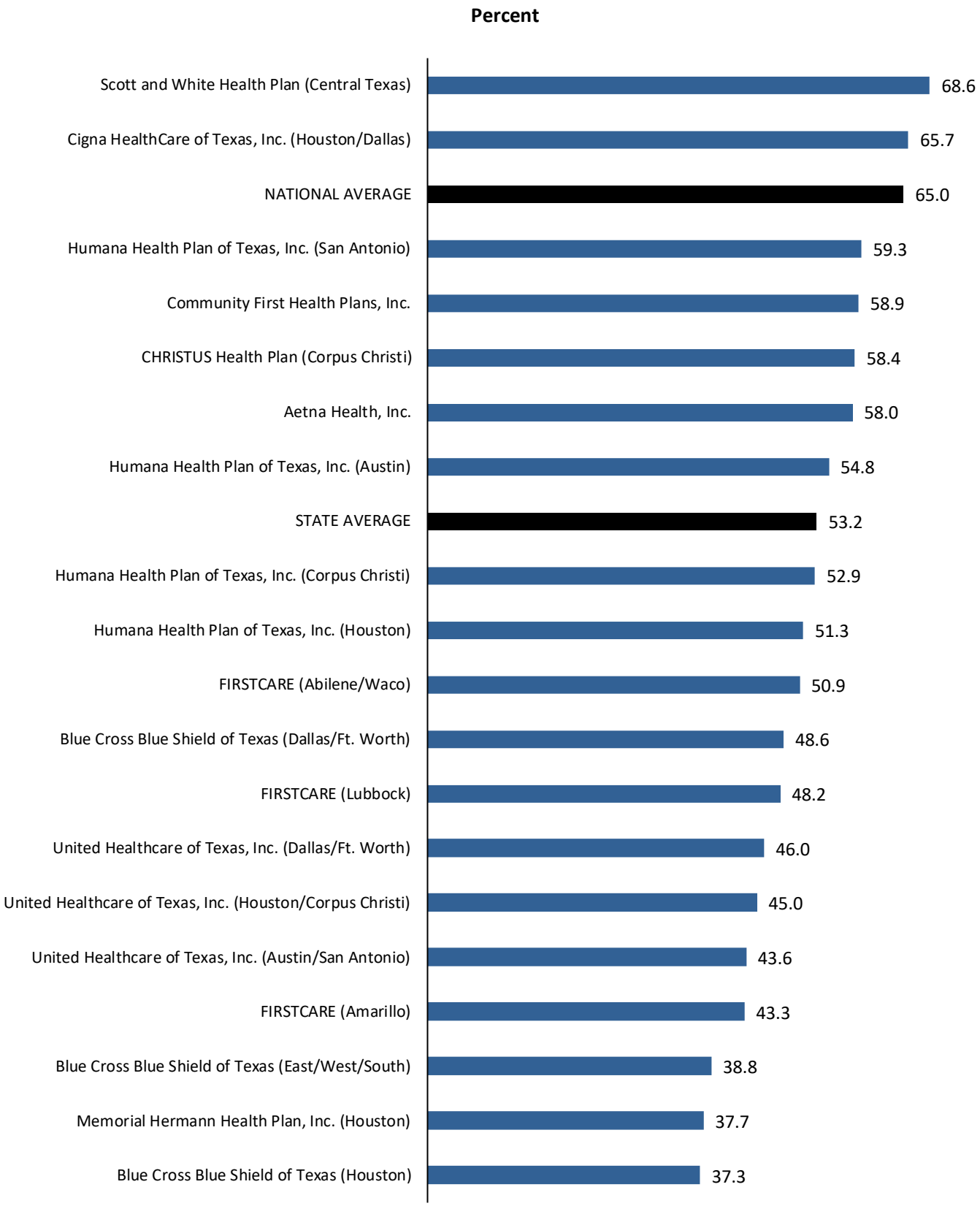
- a fecal occult blood test (FOBT) during the measurement year;
- a flexible sigmoidoscopy during the measurement year or the 4 years prior to the measurement year;
- a double contrast barium enema (DCBE) during the measurement year or the 4 years prior to the measurement year; or
- a colonoscopy during the measurement year or the 9 years prior to the measurement year.

Colorectal Cancer Screening					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	50.5%	51.8%	51.2%	52.9%	53.2%
NCQA's Quality Compass®	62.8%	62.0%	63.0%	64.1%	65.0%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

[1] American Cancer Society. *Cancer Facts and Figures 2016*. Atlanta, GA: American Cancer Society, 2016.
[2] Ibid.

Colorectal Cancer Screening Rate



Chlamydia Screening in Women

DEFINITION:

The percentage of women 16-20 or 21-24 years of age who were identified as sexually active and who had at least 1 test for chlamydia during the measurement year.

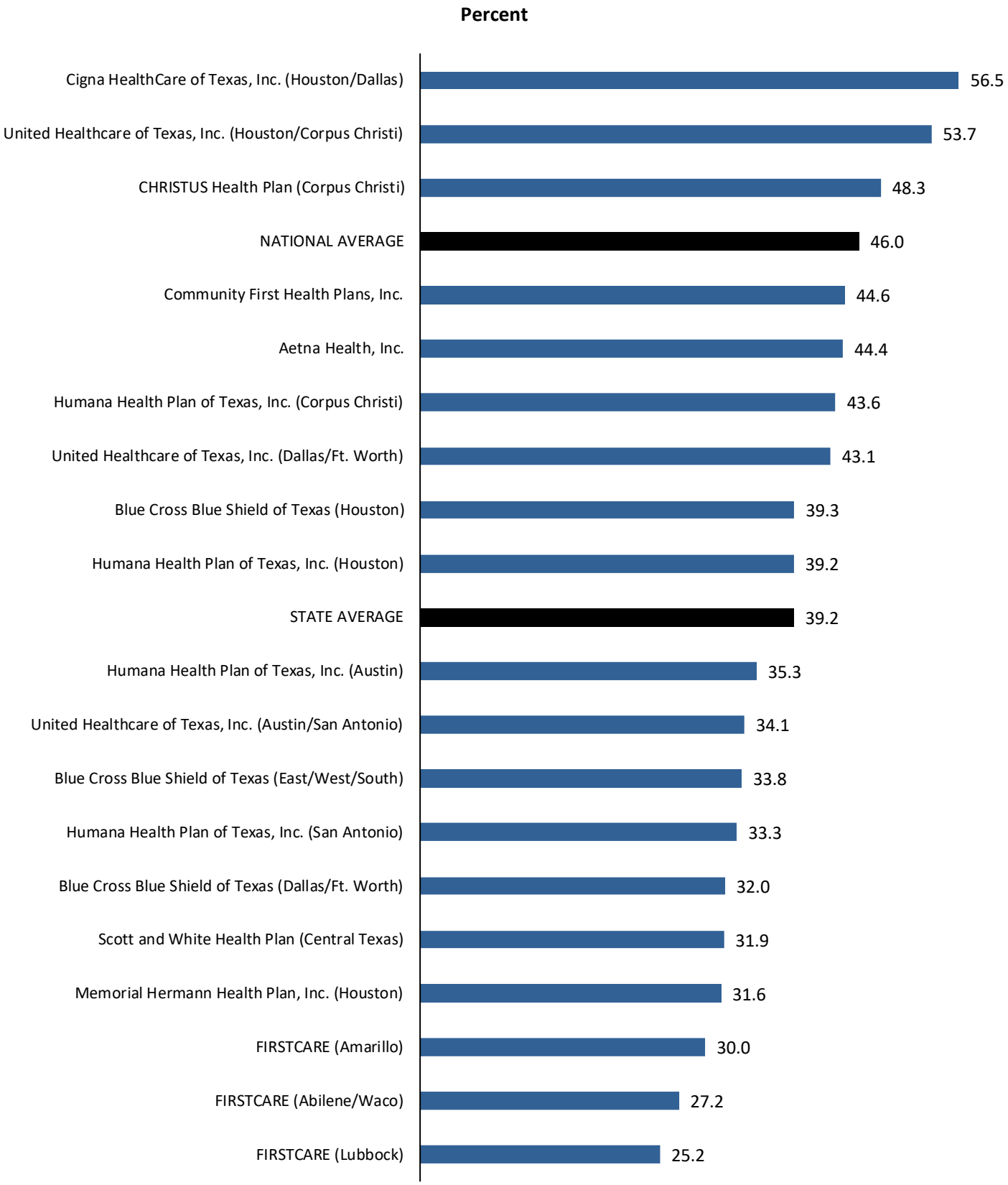
Chlamydia is a sexually transmitted bacterial infection. The Centers for Disease Control and Prevention (CDC) estimates that nearly 3 million chlamydia infections occur in the U.S. each year. The majority of infected people do not have symptoms. In women, an untreated chlamydia infection can cause damage to the reproductive system, chronic pelvic pain, and ectopic pregnancy. Sexually active adolescent and young adult women may be more susceptible to infection because the cervix has not fully matured. Antibiotics can treat and cure chlamydia.[1]

Chlamydia Screening: Total					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	44.3%	46.5%	44.7%	45.8%	47.2%
NCQA's Quality Compass®	47.4%	48.3%	48.9%	50.6%	51.5%

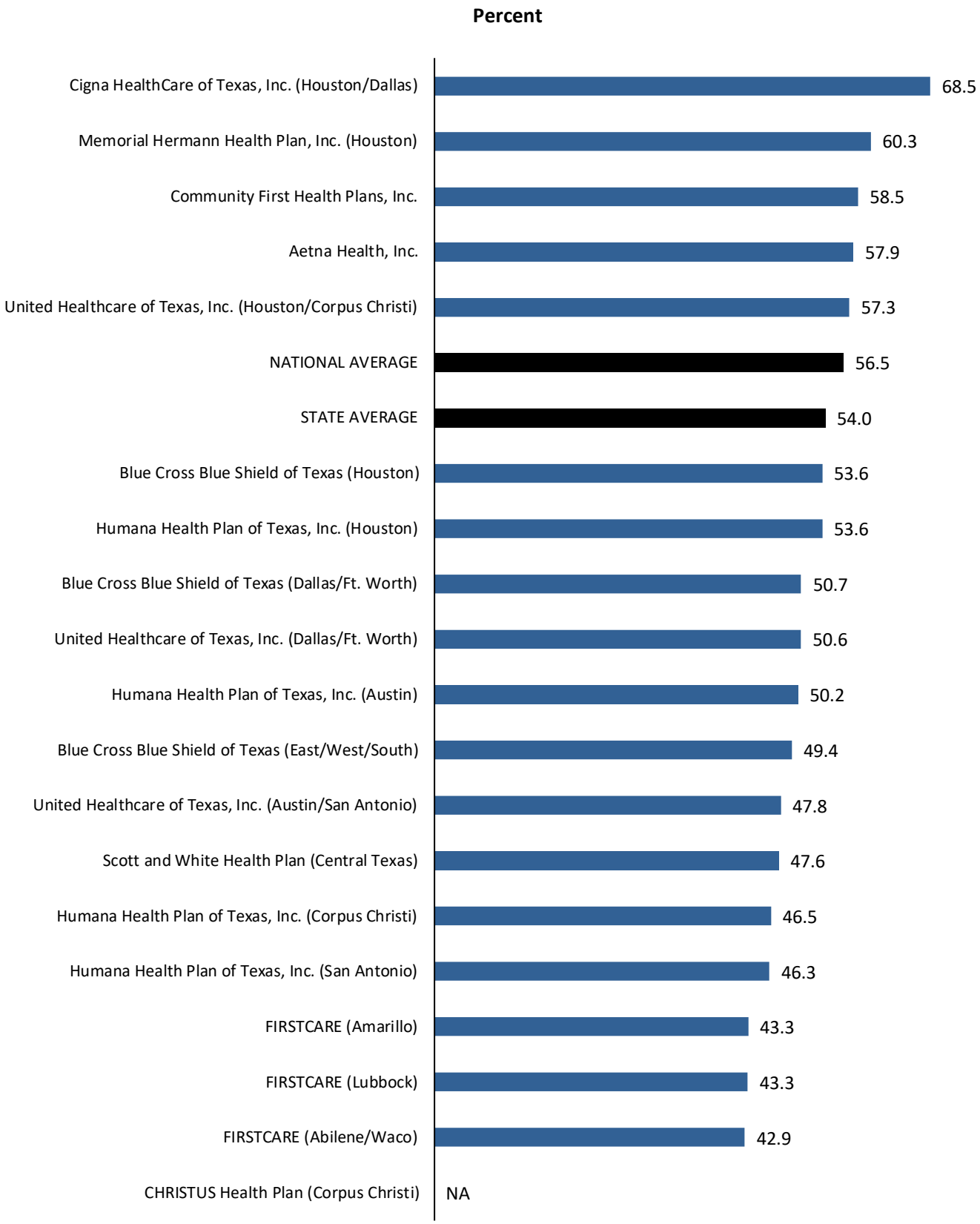
Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

[1] Centers for Disease Control and Prevention. *Chlamydia - CDC Fact Sheet*. Atlanta, GA: Centers for Disease Control and Prevention, 2016.

Chlamydia Screening Rate: Age 16-20

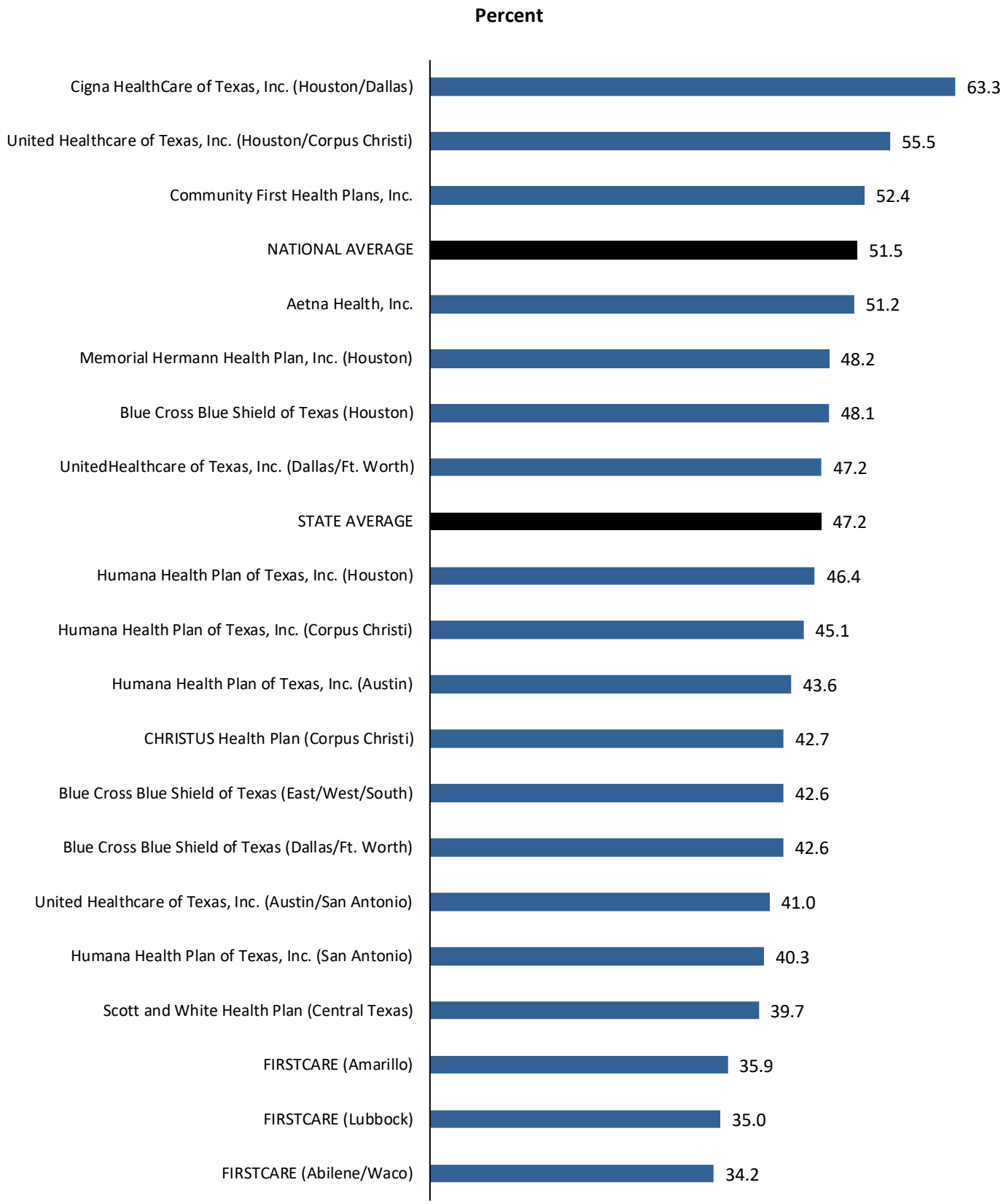


Chlamydia Screening Rate: Age 21-24



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Chlymydia Screening Rate: Total



Effectiveness of Care

Cardiovascular Conditions

Controlling High Blood Pressure

DEFINITION:

The percentage of members 18-85 years of age diagnosed with hypertension (high blood pressure), whose blood pressure was adequately controlled during the measurement year.

Adequate control is based on the following criteria: the member was 18-59 years of age whose blood pressure was <140/90 mm Hg; the member was 60-85 years of age with a diagnosis of diabetes whose blood pressure was <140/90 mm Hg; or the member was 60-85 years of age without a diagnosis of diabetes whose blood pressure was <150/90 mm Hg.

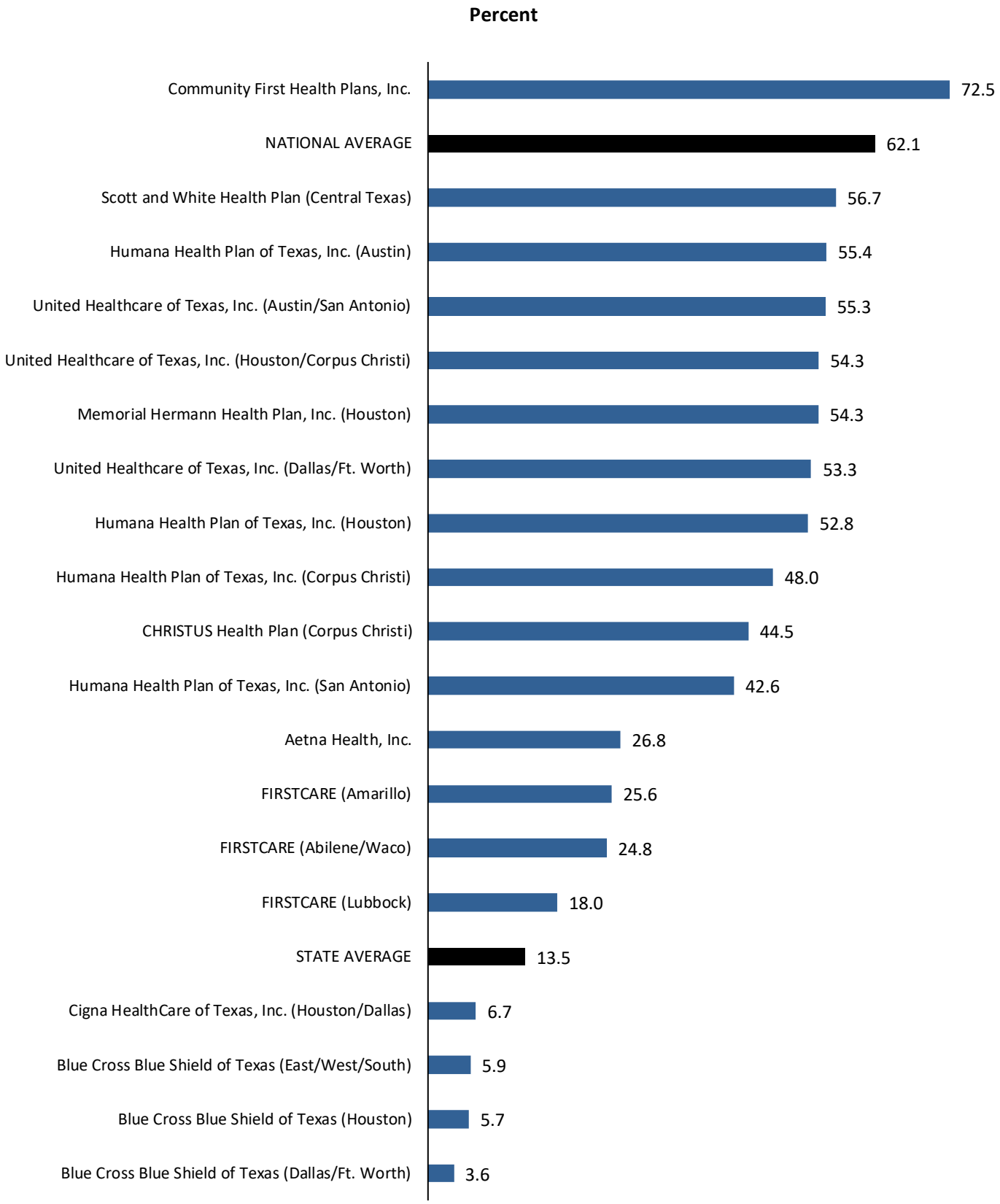
High blood pressure is a common condition that approximately 80 million American adults have according to the American Heart Association (AHA). High blood pressure (greater than 140/90 mm Hg) usually has no specific symptoms and no early warning signs. If left untreated, it increases an individual's risk for heart disease, stroke, congestive heart failure, and kidney disease.[1]

Controlling High Blood Pressure					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	55.8%	61.0%	54.7%	14.5%	13.5%
NCQA's Quality Compass®	60.5%	62.4%	62.2%	61.3%	62.1%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

[1] Mozaffarian, Dariush, et al. on behalf of the American Heart Association's Statistics Committee and Stroke Statistics Subcommittee. "Heart Disease and Stroke Statistics - 2016 Update: A Report from the American Heart Association." Circulation: *Journal of the American Heart Association*. 133: e38-e360 (2016).

Controlling High Blood Pressure



Persistence of Beta-Blocker Treatment After a Heart Attack

DEFINITION:

The percentage of members 18 years of age and older who were hospitalized during the measurement year with a diagnosis of acute myocardial infarction (AMI) and who received 6 months of beta-blocker treatment after discharge. Members who have a valid medical reason not to take the drug are excluded.

Acute myocardial infarction (AMI), also known as a heart attack, a leading cause of death in the U.S., is often caused by a blood clot that blocks one of the coronary arteries and starves the heart of oxygen-rich blood. The slow buildup of plaque in the walls of the coronary arteries narrows blood vessels and increases the risk of blockage.[1]

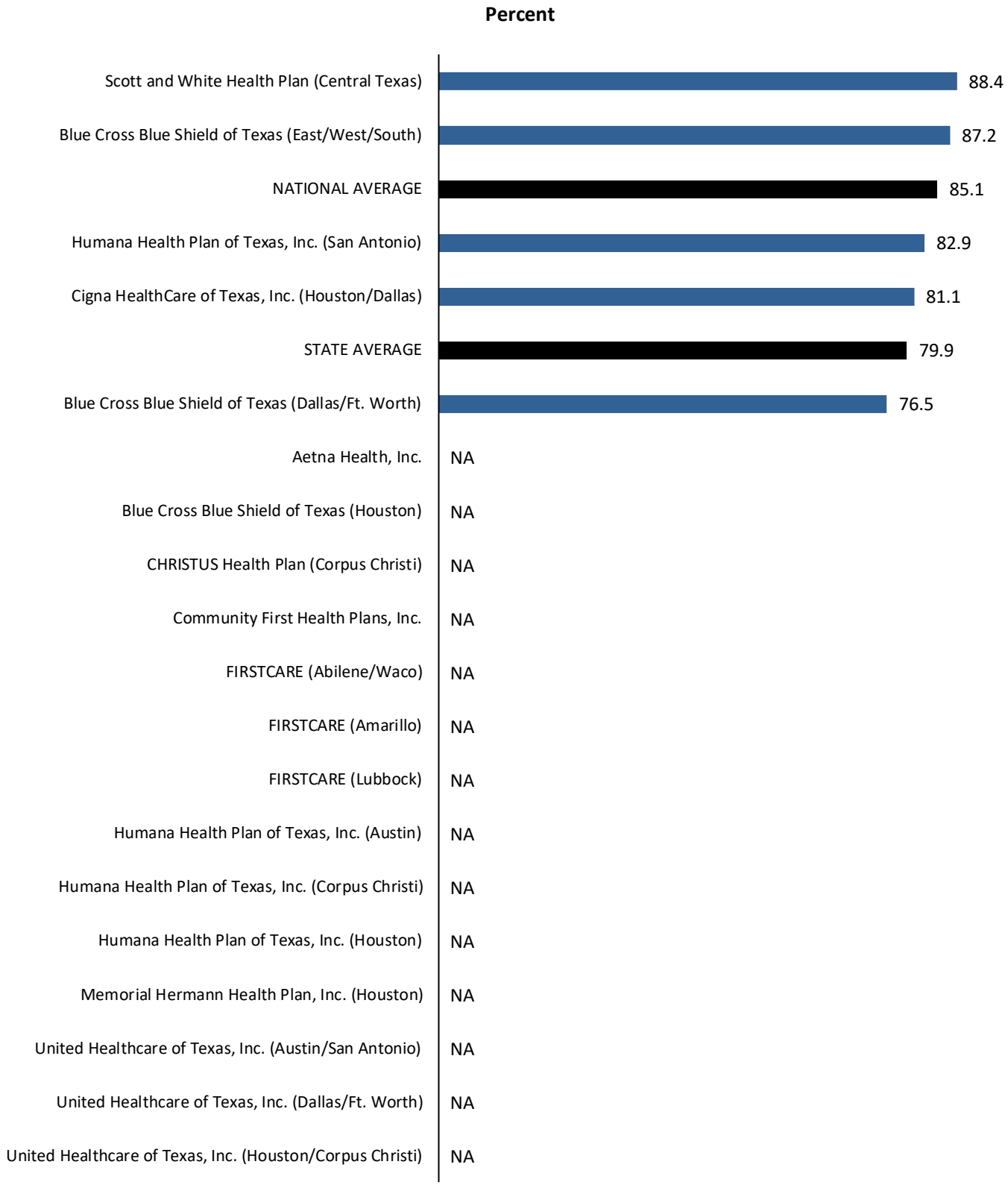
Beta-adrenergic blocking drugs, also known as beta-blockers, reduce nerve impulses to the heart and blood vessels. This slows the heart rate, relaxes pressure in the blood vessel walls, and decreases the force of heart contractions.[2] Treatment with beta-blockers has been shown to lower the risk of a subsequent AMI by reducing the heart's workload and lowering blood pressure. The American Heart Association (AHA) and the American College of Cardiology (ACC) recommend the use of beta-blockers after a heart attack to reduce the risk of a subsequent heart attack.[3]

Persistence of Beta-Blocker Treatment After a Heart Attack					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	82.5%	79.0%	74.6%	75.5%	79.9%
NCQA's Quality Compass®	84.8%	84.4%	85.4%	82.1%	85.1%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

[1] National Heart, Lung, and Blood Institute. *Health Topics: Heart Attack*. Bethesda, MD: National Heart, Lung, and Blood Institute, 2015.
[2] Ibid.
[3] Yancy, Clyde, et al. "2013 ACCF/AHA Guideline for the Management of Heart Failure." *Journal of the American College for Cardiology*. 62:e147-e239 (2013).

Persistence of Beta-Blocker Treatment After a Heart Attack



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Statin Therapy for Patients with Cardiovascular Disease

DEFINITION:

The percentage of males 21-75 years of age and females 40-75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported:

1. **Received Statin Therapy**. Members who were dispensed at least 1 high or moderate-intensity statin medication during the measurement year.
2. **Statin Adherence 80%**. Members who remained on a high or moderate-intensity statin medication for at least 80% of the treatment period.

Statins (HMG CoA reductase inhibitors) are a class of drugs that lower blood cholesterol. Statins work in the liver by preventing the formation of cholesterol, thus lowering the amount of cholesterol in the blood.[1] Statins are most effective in lowering low-density lipoprotein cholesterol (LDL-C). The amount of cholesterol-lowering effect is based on statin intensity, which is classified as either high, moderate, or low.

This measure was added to the Texas Subset beginning with HEDIS® 2017.

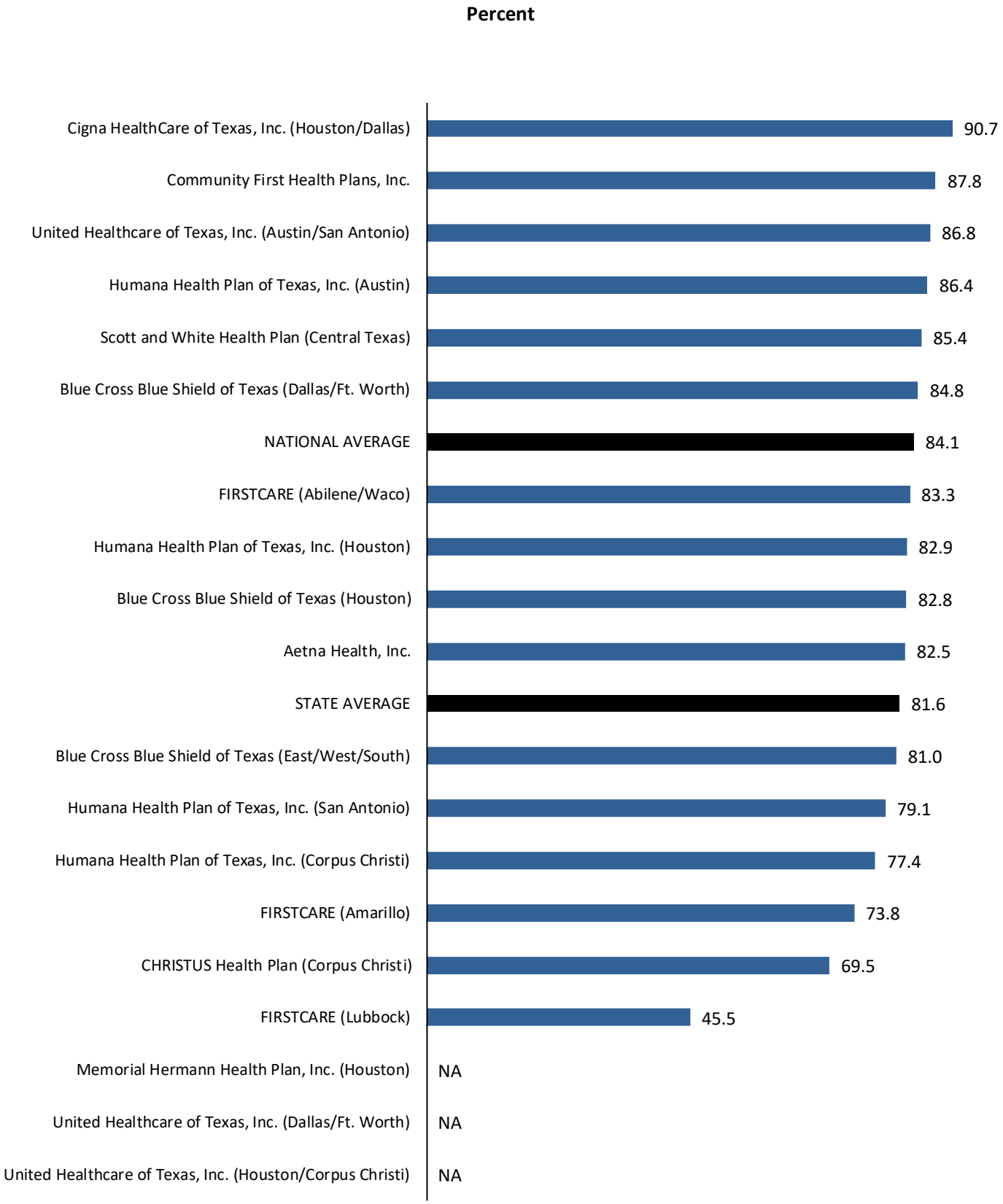
Statin Therapy for Patients with Cardiovascular Disease: Total

	2016		2017		2018		2019		2020	
	TX	QC	TX	QC	TX	QC	TX	QC	TX	QC
Received Statin Therapy	**	**	79.9%	**	75.5%	80.4%	77.8%	80.7%	79.1%	81.9%
Statin Adherence 80%	**	**	65.3%	**	69.9%	73.5%	75.8%	75.9%	73.8%	76.6%

Quality Compass® (QC) is a national database of health plan-specific performance information voluntarily reported to the NCQA.
** Value not established or not obtained.

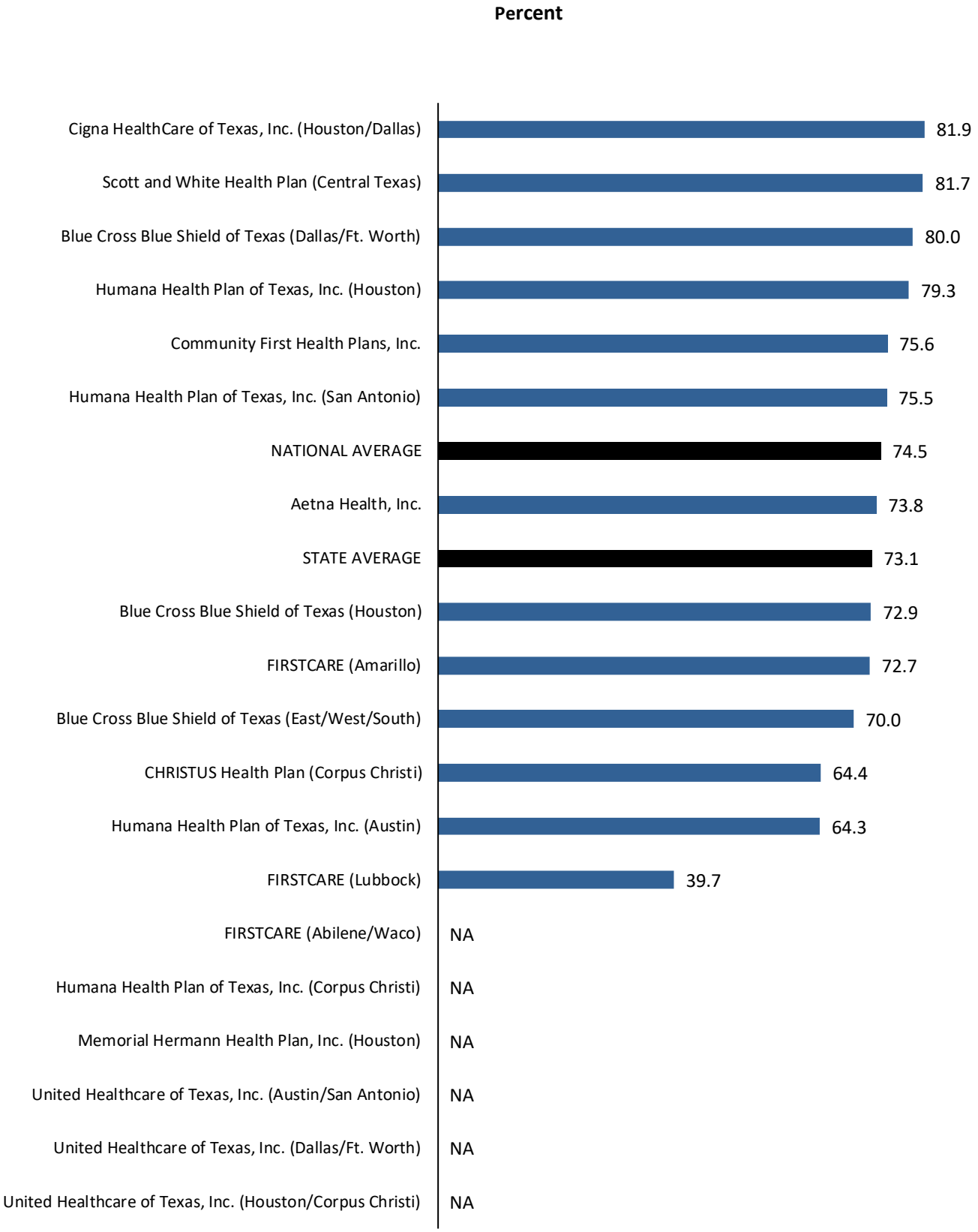
[1] American Heart Association (AHA). 2014. "Drug Therapy for Cholesterol." www.heart.org/HEARTORG/Conditions/Cholesterol/PreventionTreatmentofHighCholesterol/Drug-Therapy-for-Cholesterol_UCM_305632_Article.jsp

Received Statin Therapy - Males Age 21-75



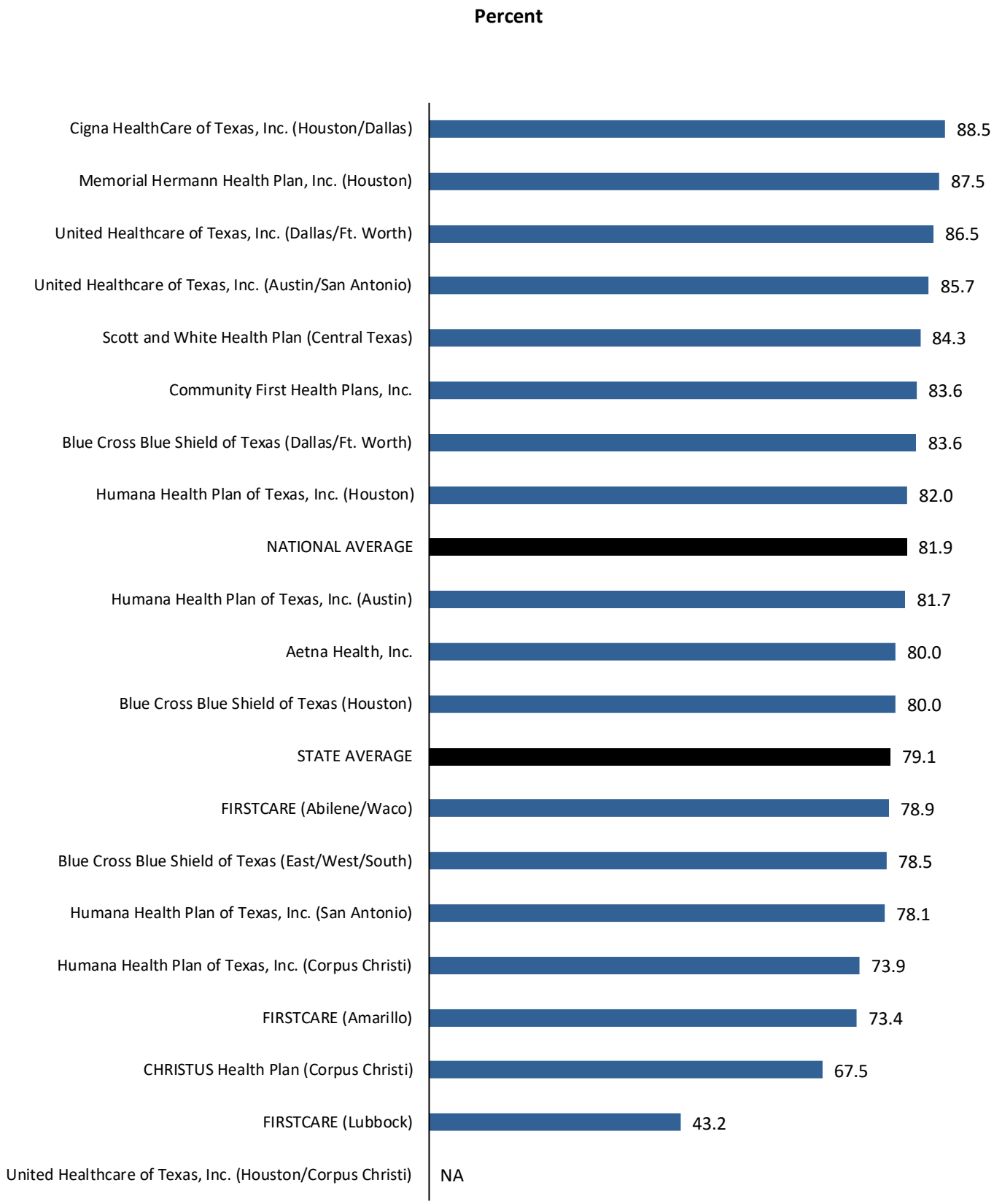
NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Received Statin Therapy - Females Age 40-75



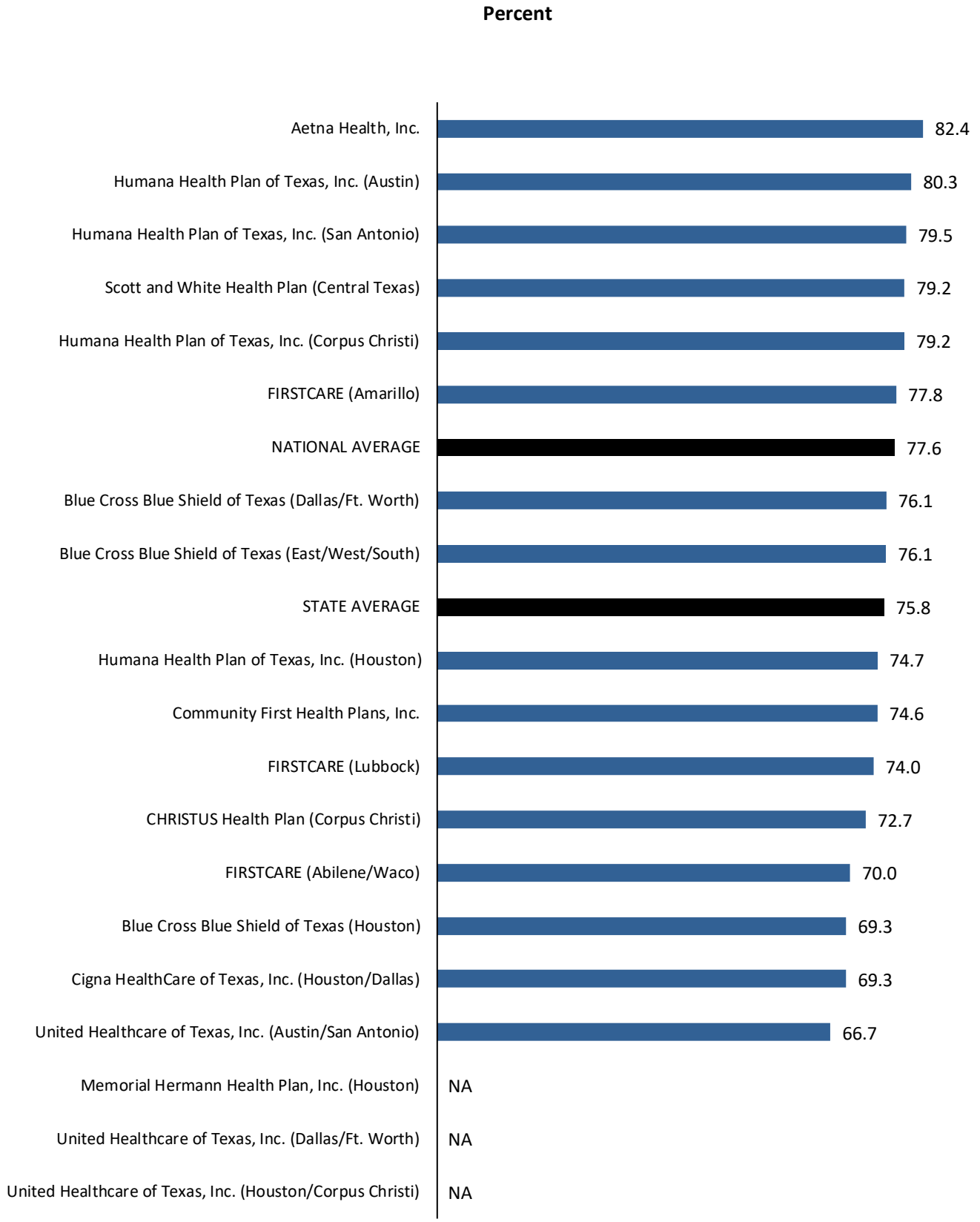
NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Received Statin Therapy: Total



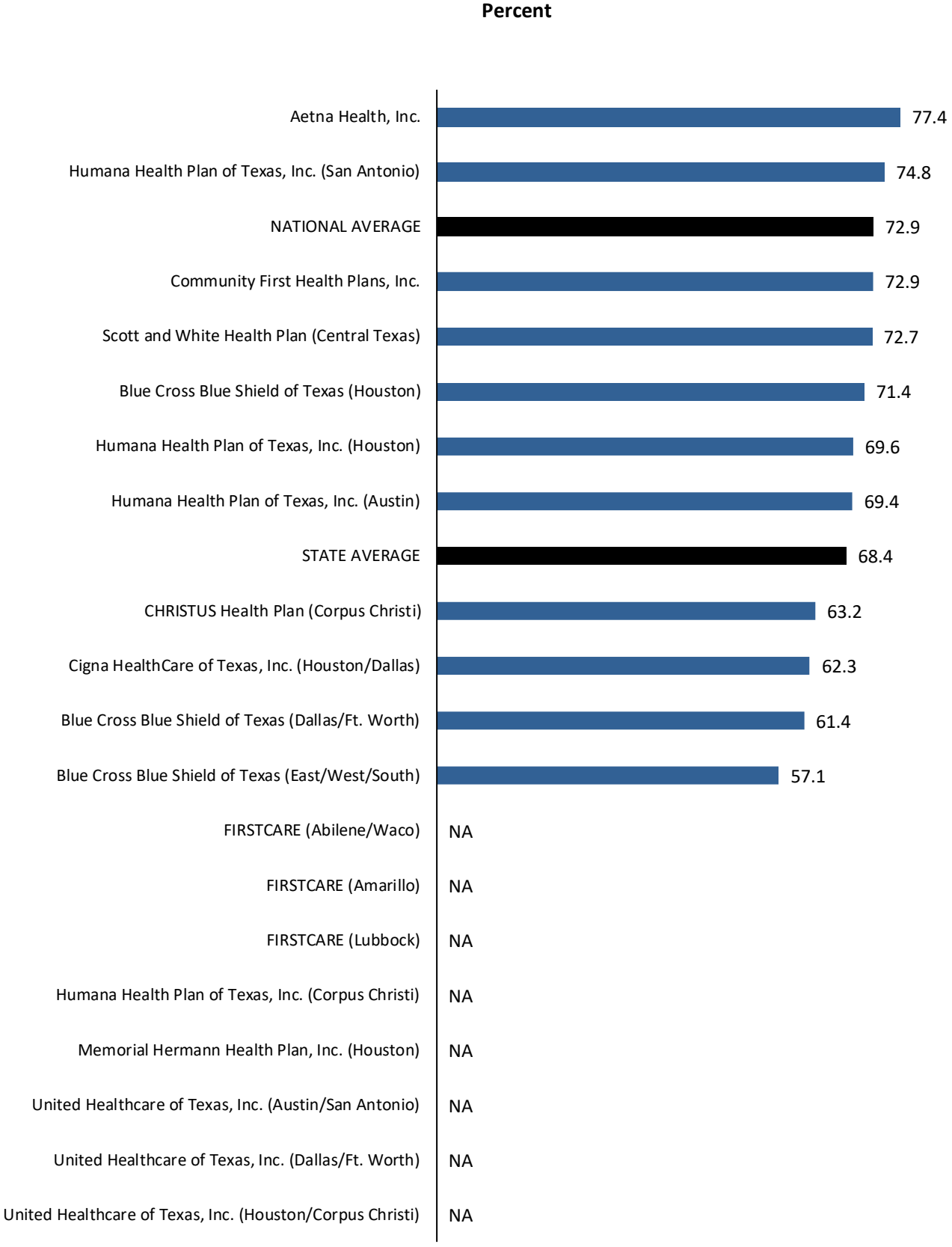
NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Statin Adherence 80% - Males Age 21-75



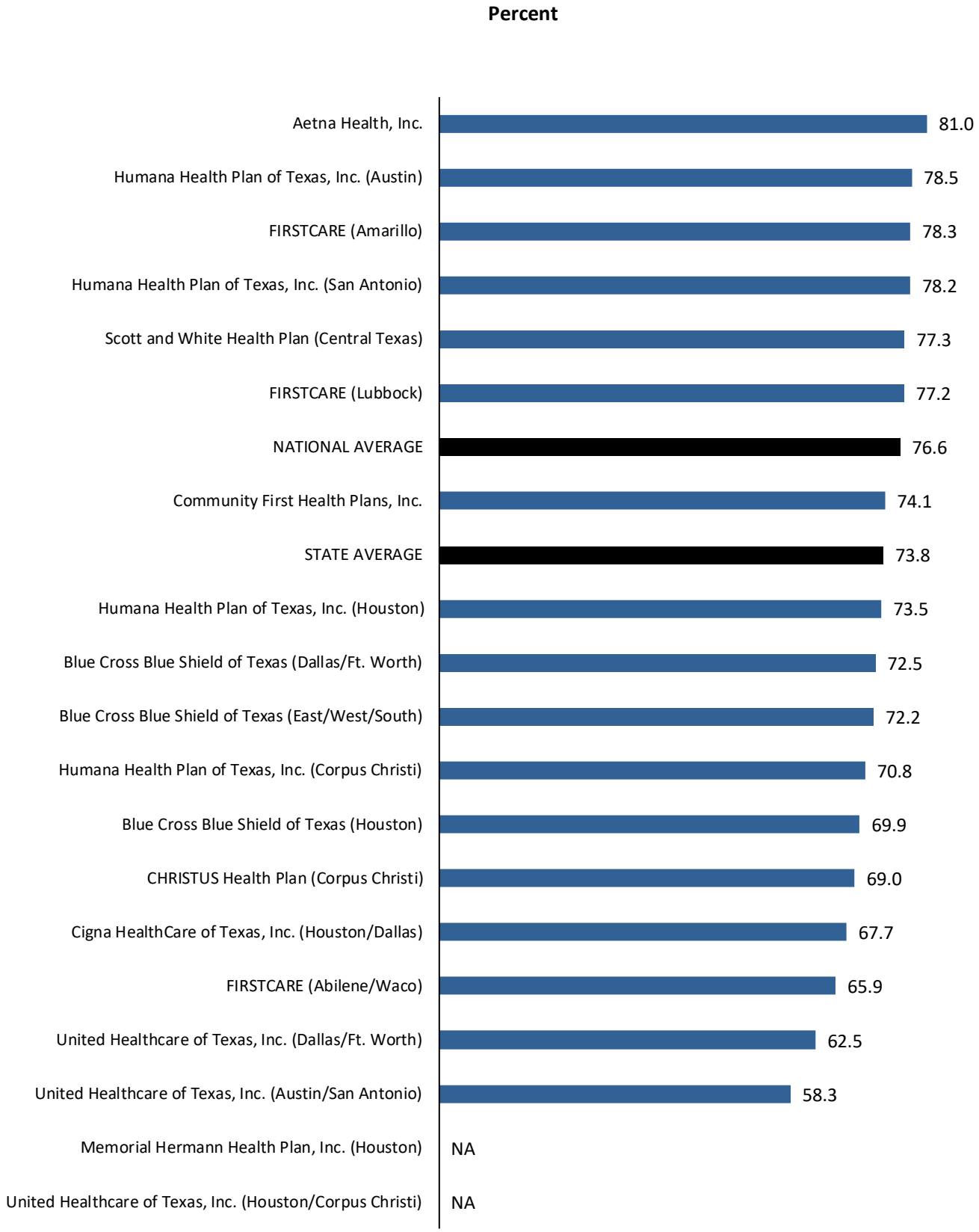
NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Statin Adherence 80% - Females Age 40-75



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Statin Adherence 80% - Total



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Effectiveness of Care

Diabetes

Comprehensive Diabetes Care: HbA1c Testing

DEFINITION:

The percentage of members 18-75 years of age with Type 1 or Type 2 Diabetes who had 1 or more hemoglobin A1c (HbA1c) tests conducted within the past year.

Diabetes is associated with serious complications, including heart disease and stroke, blindness, kidney failure, and lower-limb amputation.

The HbA1c test is one of the tests used to monitor individuals with diabetes. It measures average blood glucose control during the previous months. Diabetics who maintain HbA1c levels under 7% have a much better chance of delaying or preventing complications that affect the eyes, kidneys, and nerves than diabetics with levels of 8% or higher.[1] The American Diabetes Association (ADA) recommends a therapeutic goal of 7% and encourages physicians to reevaluate treatment regimes in patients with levels consistently above 8%. HbA1c levels over 9% indicate poorly controlled diabetes.[2]

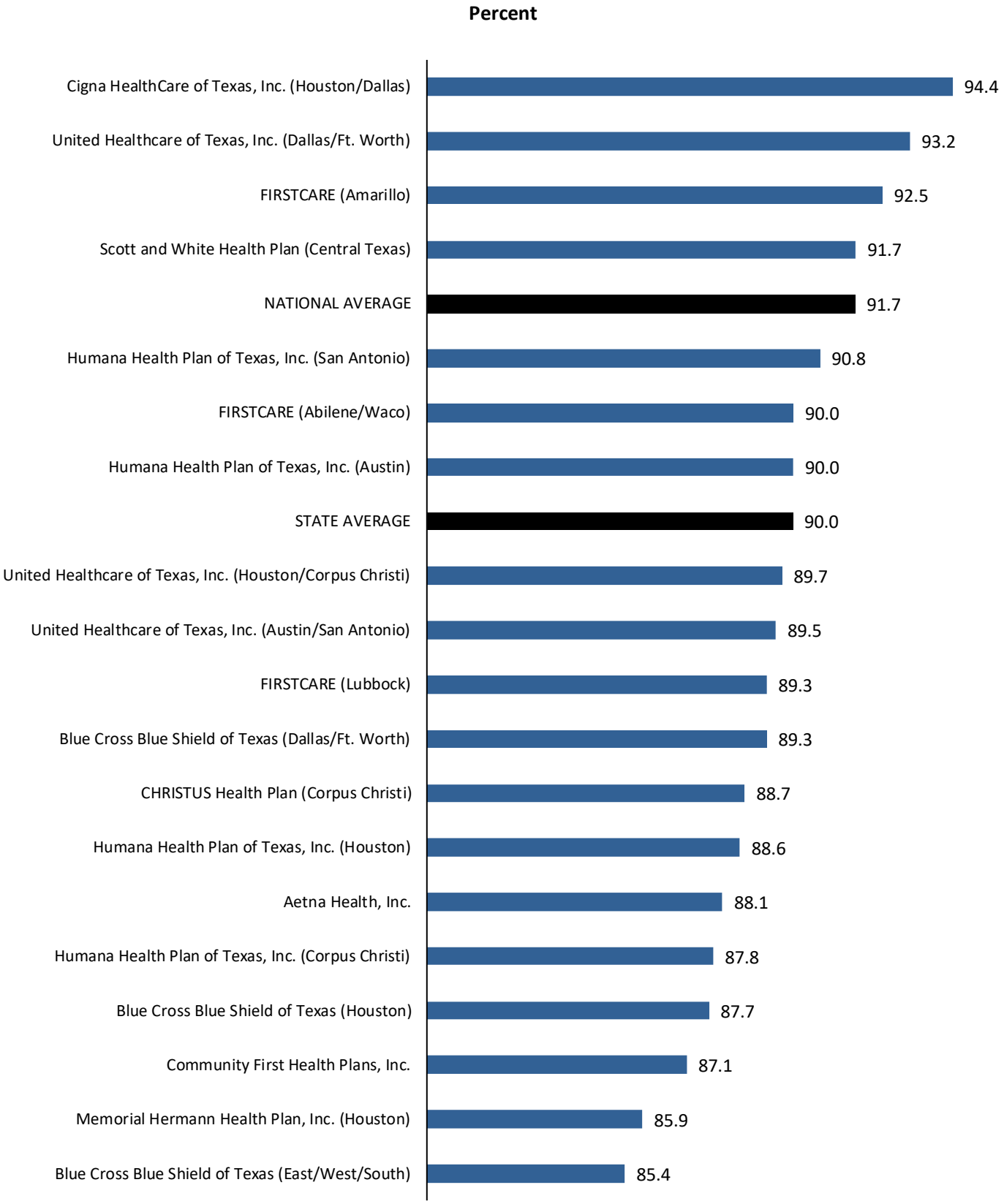
ADA recommends that an individual diagnosed with diabetes have this test performed at least twice a year. An individual with diabetes should continue to perform daily self-tests to monitor day-to-day blood glucose control.[3]

HbA1c Testing					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	90.1%	90.4%	90.3%	89.7%	90.0%
NCQA's Quality Compass®	90.1%	90.6%	91.2%	91.3%	91.7%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

[1] Centers for Disease Control and Prevention. *2014 National Diabetes Statistics Report*. Atlanta, GA: Centers for Disease Control and Prevention, 2014.
[2] American Diabetes Association. *Living with Diabetes: A1c and eAG*. Alexandria, VA: American Diabetes Association, 2014.
[3] Ibid.

HbA1c Testing



Comprehensive Diabetes Care: Poor HbA1c Control (>9%)

DEFINITION:

The percentage of members 18-75 years of age with Type 1 or Type 2 Diabetes who had their most recent HbA1c level greater than 9% during the past year.

Diabetes is associated with serious complications, including heart disease and stroke, blindness, kidney failure, and lower-limb amputation.

The HbA1c test is one of the tests used to monitor individuals with diabetes. It measures average blood glucose control during the previous months. Diabetics who maintain HbA1c levels under 7% have a much better chance of delaying or preventing complications that affect the eyes, kidneys, and nerves than diabetics with levels of 8% or higher.[1] The American Diabetes Association (ADA) recommends a therapeutic goal of 7% and encourages physicians to reevaluate treatment regimes in patients with levels consistently above 8%. HbA1c levels over 9% indicate poorly controlled diabetes.[2]

ADA recommends that an individual diagnosed with diabetes have this test performed at least twice a year. An individual with diabetes should continue to perform daily self-tests to monitor day-to-day blood glucose control.[3]

**Note: Lower rates indicate better performance for this measure.*

Poor HbA1c Control (>9%)					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	56.8%	50.2%	48.2%	51.6%	52.7%
NCQA's Quality Compass®	33.8%	33.0%	31.7%	30.4%	29.8%

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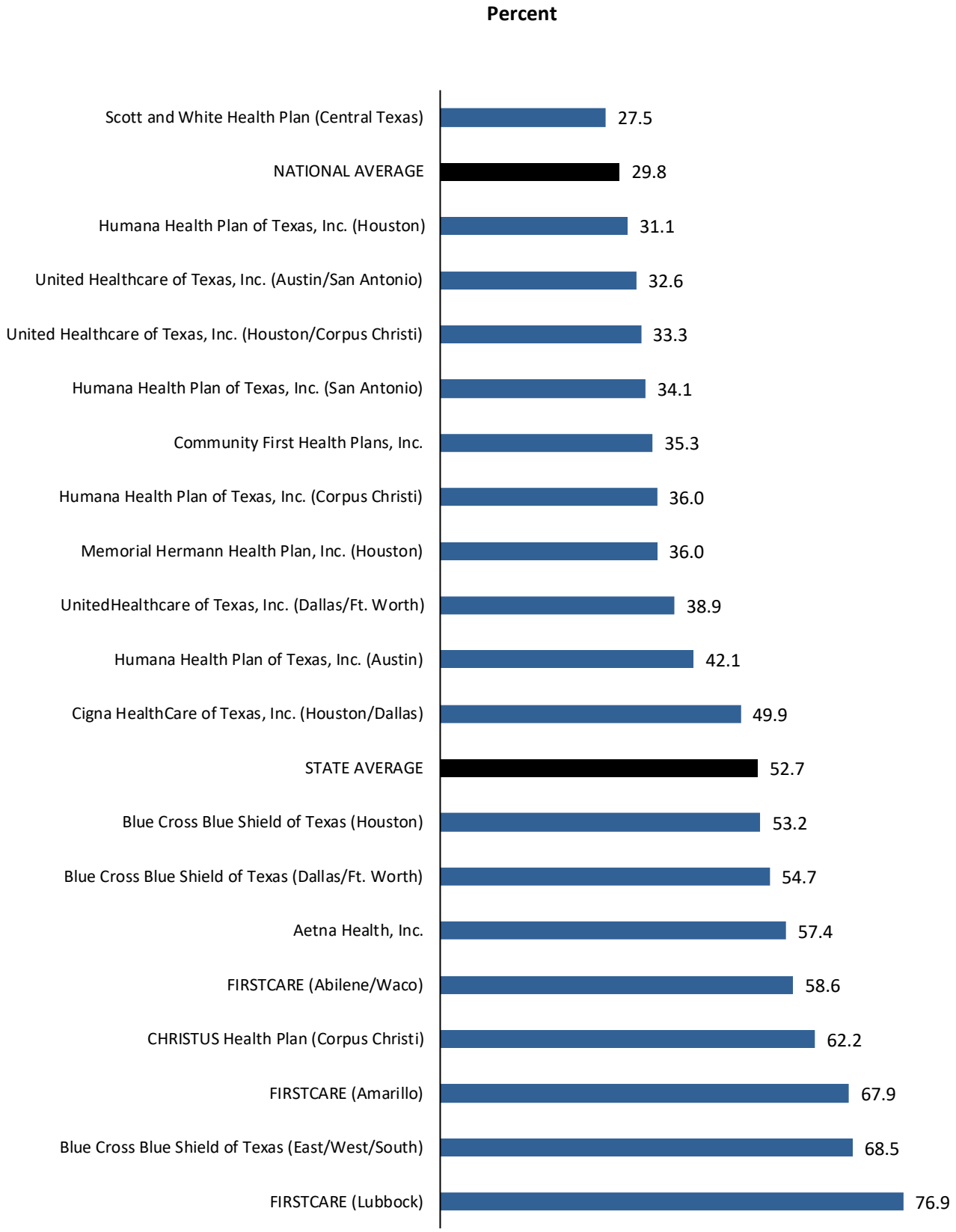
[1] Centers for Disease Control and Prevention. *2014 National Diabetes Statistics Report*. Atlanta, GA: Centers for Disease Control and Prevention, 2014.
[2] American Diabetes Association. *Living with Diabetes: A1c and eAG*. Alexandria, VA: American Diabetes Association, 2014.
[3] Ibid.

Poor HbA1c Control (>9%)



Note: Lower rates indicate better performance for this measure.

Comprehensive Diabetes Care: HbA1c Control (<8%)

DEFINITION:

The percentage of members 18-75 years of age with Type 1 or Type 2 Diabetes who had their most recent HbA1c level less than 8% during the past year.

Diabetes is associated with serious complications, including heart disease and stroke, blindness, kidney failure, and lower-limb amputation.

The HbA1c test is one of the tests used to monitor individuals with diabetes. It measures average blood glucose control during the previous months. Diabetics who maintain HbA1c levels under 7% have a much better chance of delaying or preventing complications that affect the eyes, kidneys, and nerves than diabetics with levels of 8% or higher.[1] The American Diabetes Association (ADA) recommends a therapeutic goal of 7% and encourages physicians to reevaluate treatment regimes in patients with levels consistently above 8%. HbA1c levels over 9% indicate poorly controlled diabetes.[2]

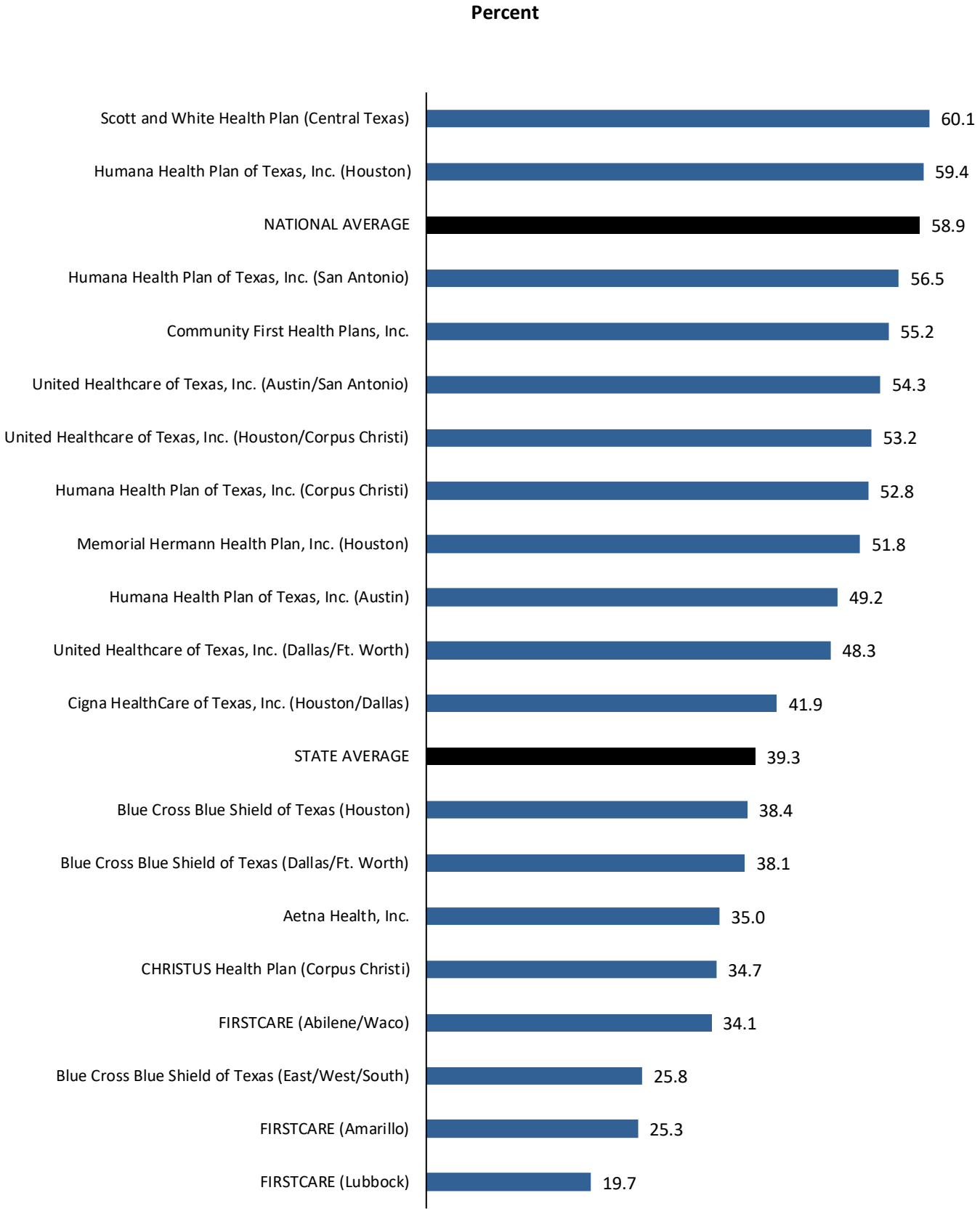
ADA recommends that an individual diagnosed with diabetes have this test performed at least twice a year. An individual with diabetes should continue to perform daily self-tests to monitor day-to-day blood glucose control.[3]

HbA1c Control (<8%)					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	35.9%	40.8%	43.2%	40.1%	39.3%
NCQA's Quality Compass®	55.3%	56.1%	57.6%	58.2%	58.9%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

[1] Centers for Disease Control and Prevention. *2014 National Diabetes Statistics Report*. Atlanta, GA: Centers for Disease Control and Prevention, 2014.
[2] American Diabetes Association. *Living with Diabetes: A1c and eAG*. Alexandria, VA: American Diabetes Association, 2014.
[3] Ibid.

HbA1c Control (<8%)



Comprehensive Diabetes Care: HbA1c Control (<7%)

DEFINITION:

The percentage of members 18-75 years of age with Type 1 or Type 2 Diabetes who had their most recent HbA1c level less than 7% during the past year.

Diabetes is associated with serious complications, including heart disease and stroke, blindness, kidney failure, and lower-limb amputation.

The HbA1c test is one of the tests used to monitor individuals with diabetes. It measures average blood glucose control during the previous months. Diabetics who maintain HbA1c levels under 7% have a much better chance of delaying or preventing complications that affect the eyes, kidneys, and nerves than diabetics with levels of 8% or higher.[1] The American Diabetes Association (ADA) recommends a therapeutic goal of 7% and encourages physicians to reevaluate treatment regimes in patients with levels consistently above 8%. HbA1c levels over 9% indicate poorly controlled diabetes.[2]

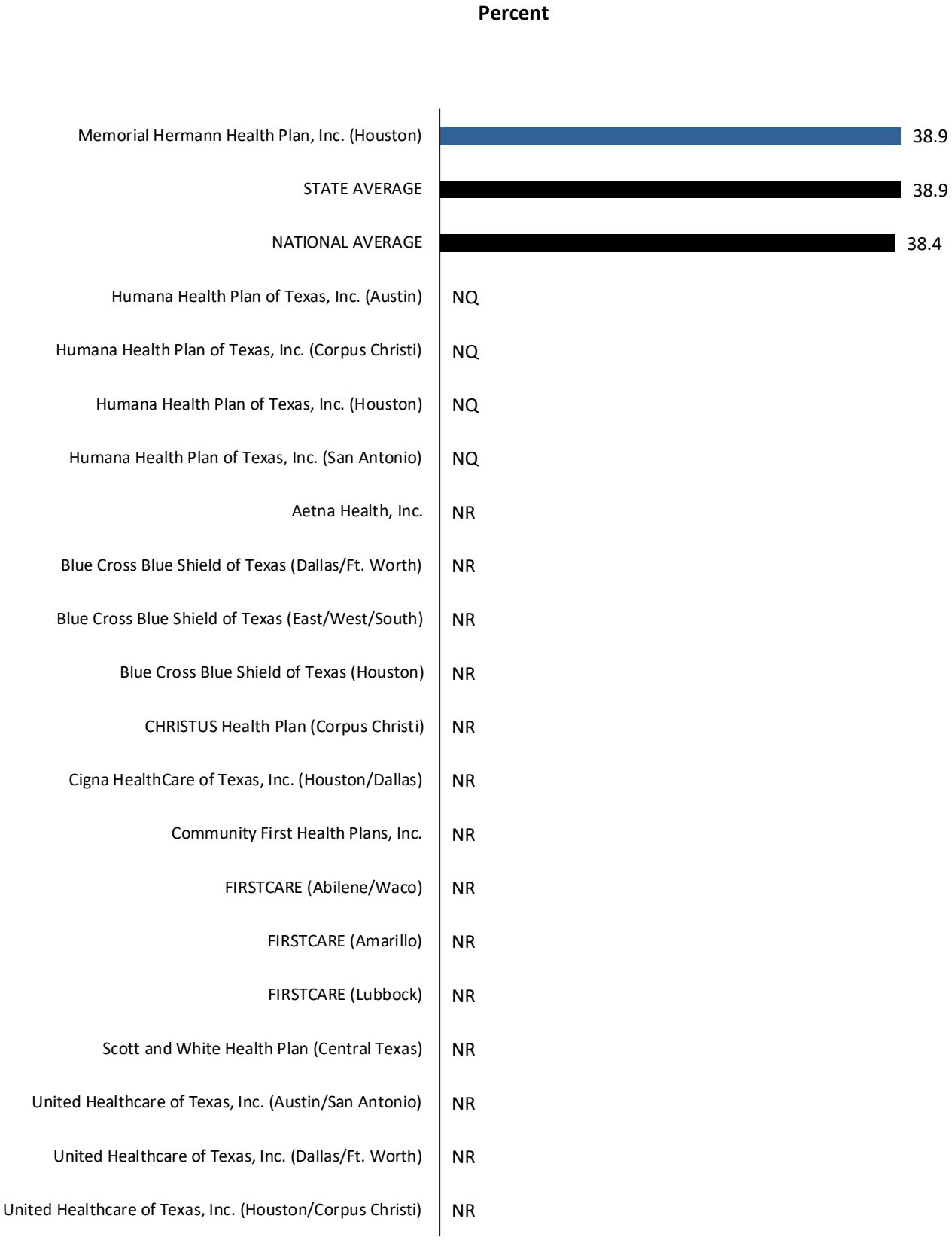
ADA recommends that an individual diagnosed with diabetes have this test performed at least twice a year. An individual with diabetes should continue to perform daily self-tests to monitor day-to-day blood glucose control.[3]

HbA1c Control (<7%)					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	30.4%	33.1%	31.0%	36.1%	38.9%
NCQA's Quality Compass®	36.7%	37.7%	38.9%	38.4%	38.4%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

[1] Centers for Disease Control and Prevention. *2014 National Diabetes Statistics Report*. Atlanta, GA: Centers for Disease Control and Prevention, 2014.
[2] American Diabetes Association. *Living with Diabetes: A1c and eAG*. Alexandria, VA: American Diabetes Association, 2014.
[3] Ibid.

HbA1c Control (<7%)



NQ - Not Required. The organization was not required to report the measure.
NR - Not Reported. The organization chose not to report the meausre.

Comprehensive Diabetes Care: Eye Exam

DEFINITION:

The percentage of members 18-75 years of age with Type 1 or Type 2 Diabetes who had an eye screening for diabetic retinal disease within the past year or a negative retinal exam the previous year.

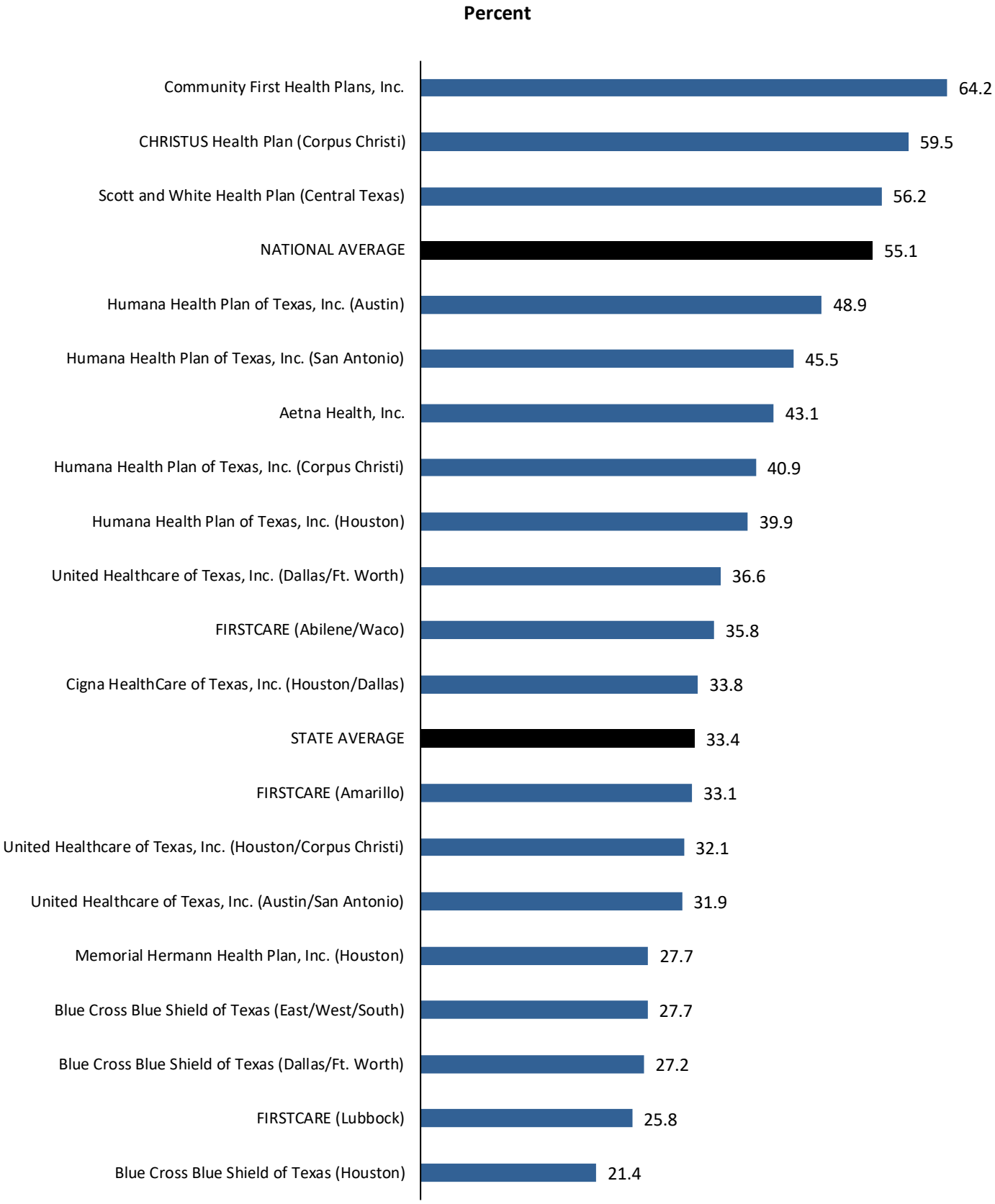
Diabetic retinopathy is caused by changes in the blood vessels in the retina. It is the most common diabetic eye disease and a leading cause of blindness in American adults. In some people with diabetic retinopathy, blood vessels swell and leak fluid. In others, abnormal new blood vessels grow on the surface of the retina. Between 40-45% of Americans diagnosed with diabetes have some stage of diabetic retinopathy. Individuals with proliferative retinopathy can reduce their risk of blindness by 95% with timely treatment and appropriate follow-up care.[1]

Eye Exam					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	30.5%	31.9%	33.6%	33.1%	33.4%
NCQA's Quality Compass®	53.7%	53.6%	55.0%	55.9%	55.1%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

[1] National Eye Institute. *Facts About Diabetic Eye Disease*. Bethesda, MD: National Eye Institute, 2015.

Eye Exam


Percent
Community First Health Plans, Inc. 64.2
CHRISTUS Health Plan (Corpus Christi) 59.5
Scott and White Health Plan (Central Texas) 56.2
NATIONAL AVERAGE 55.1
Humana Health Plan of Texas, Inc. (Austin) 48.9
Humana Health Plan of Texas, Inc. (San Antonio) 45.5
Aetna Health, Inc. 43.1
Humana Health Plan of Texas, Inc. (Corpus Christi) 40.9
Humana Health Plan of Texas, Inc. (Houston) 39.9
United Healthcare of Texas, Inc. (Dallas/Ft. Worth) 36.6
FIRSTCARE (Abilene/Waco) 35.8
Cigna HealthCare of Texas, Inc. (Houston/Dallas) 33.8
STATE AVERAGE 33.4
FIRSTCARE (Amarillo) 33.1
United Healthcare of Texas, Inc. (Houston/Corpus Christi) 32.1
United Healthcare of Texas, Inc. (Austin/San Antonio) 31.9
Memorial Hermann Health Plan, Inc. (Houston) 27.7
Blue Cross Blue Shield of Texas (East/West/South) 27.7
Blue Cross Blue Shield of Texas (Dallas/Ft. Worth) 27.2
FIRSTCARE (Lubbock) 25.8
Blue Cross Blue Shield of Texas (Houston) 21.4

Comprehensive Diabetes Care: Medical Attention for Diabetic Nephropathy

DEFINITION:

The percentage of members 18-75 years of age with Type 1 or Type 2 Diabetes who received medical attention for nephropathy or evidence of already having nephropathy within the past year.

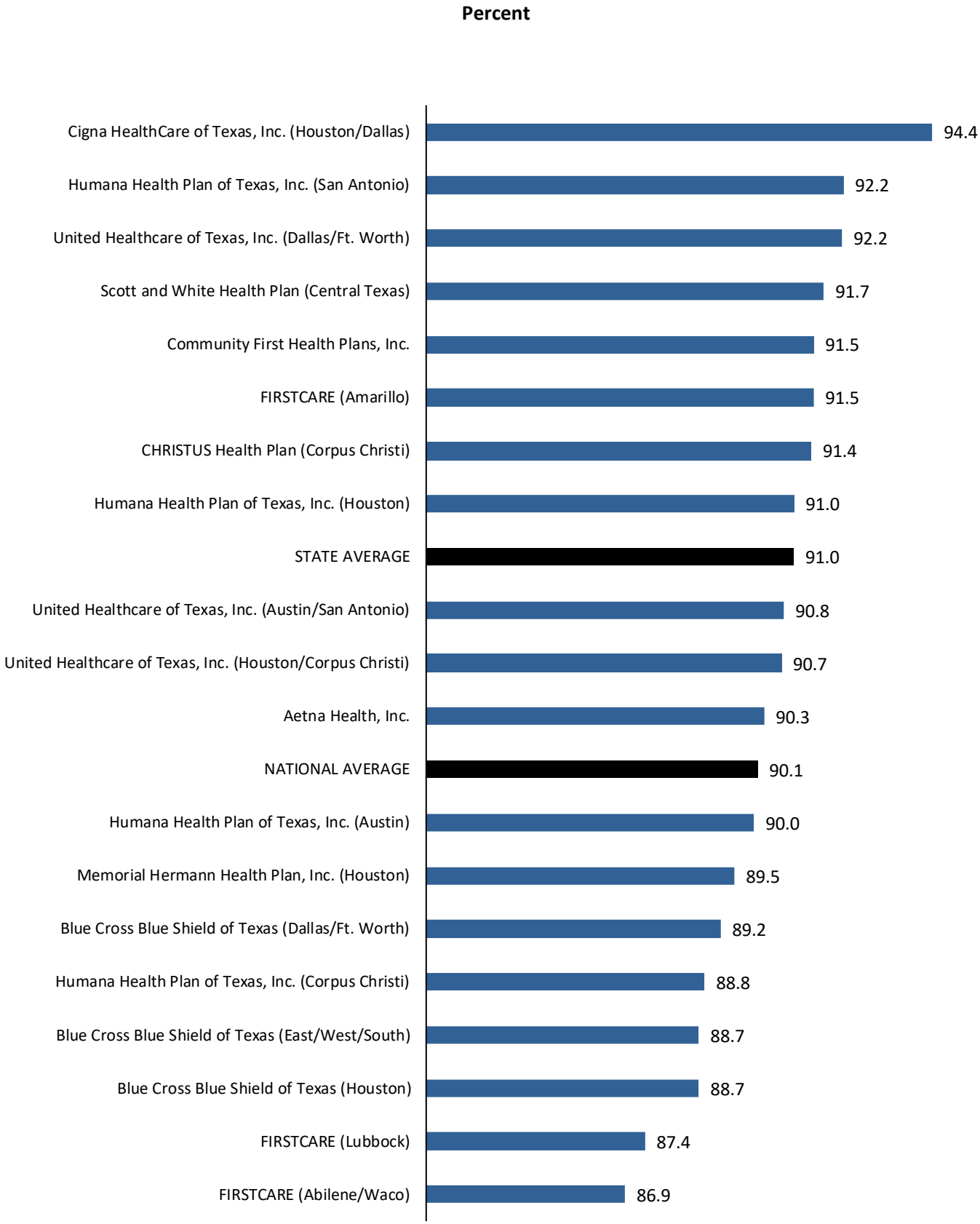
Diabetic nephropathy, or kidney disease, is a frequent complication of diabetes. Diabetic nephropathy is a progressive disease that develops over several years. In healthy individuals, many tiny vessels (nephrons) in the kidneys filter wastes, chemicals, and excess water from the blood. When an individual has diabetic nephropathy, the nephrons become damaged, leaky, and eventually quit working. The stress on the remaining nephrons damages them as well. When the filtration system breaks down, the kidneys fail to function causing end-stage renal disease (ESRD). An individual with ESRD will require dialysis or a kidney transplant in order to survive.[1]

Medical Attention for Diabetic Nephropathy					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	90.8%	91.8%	91.0%	91.0%	91.0%
NCQA's Quality Compass®	90.4%	90.2%	90.4%	90.3%	90.1%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

[1] National Institute of Diabetes and Digestive and Kidney Disease. *Glomerular Diseases*. Bethesda, MD: National Institutes of Health, 2014.

Medical Attention for Diabetic Nephropathy



Comprehensive Diabetes Care:
Blood Pressure Control (<140/90 mm Hg)

DEFINITION:

The percentage of members 18-75 years of age with Type 1 or Type 2 Diabetes who had their most recent blood pressure reading at less than 140 mm Hg systolic and 90 mm Hg diastolic during the past year.

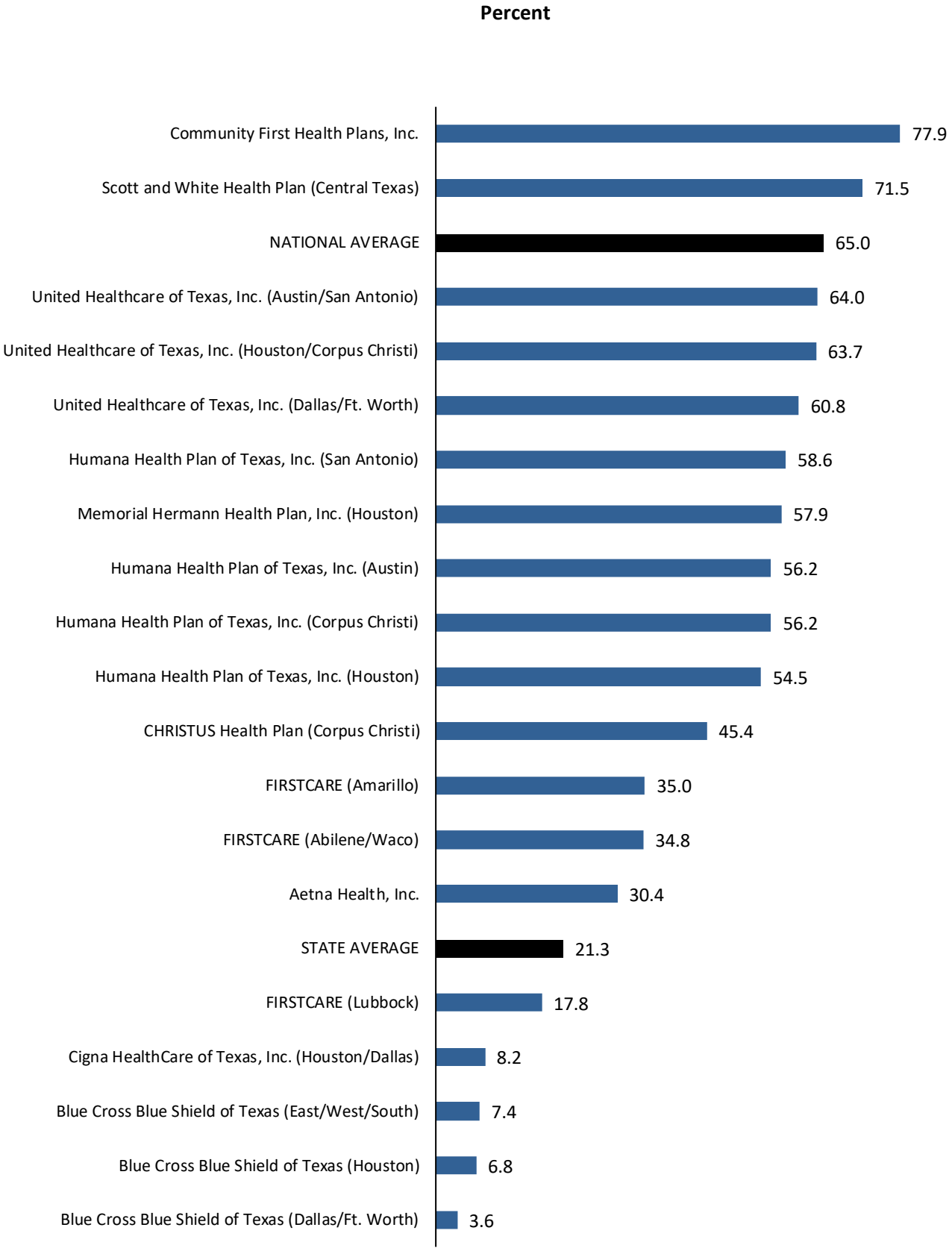
Adults with diabetes are 2-4 times more likely to have cardiovascular disease (heart disease or stroke) than individuals without diabetes. Blood pressure control can reduce the risk of heart attack and stroke as well as other diabetes related complications such as retinopathy (damage to the blood vessels in the retina) and nephropathy (damage to blood vessels in the kidneys).[1] The National Institutes of Health (NIH) recommends that individuals with diabetes maintain their blood pressure below 130/80 mm Hg.[2]

Blood Pressure Control (<140/90 mm Hg)					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	22.3%	19.4%	20.9%	22.3%	21.3%
NCQA's Quality Compass®	60.2%	61.6%	62.2%	64.2%	65.0%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

[1] American Diabetes Association. *Living with Diabetes: High Blood Pressure (Hypertension).* Alexandria, VA: American Diabetes Association, 2014.
[2] National Heart, Lung, and Blood Institute. *Health Topics: High Blood Pressure*. Bethesda, MD: National Institutes of Health, 2015.

Blood Pressure Control (<140/90 mm Hg)



Statin Therapy for Patients with Diabetes

DEFINITION:

The percentage of members 40-75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. Two rates are reported:

1. **Received Statin Therapy**. Members who were dispensed at least 1 statin medication of any intensity during the measurement year.
2. **Statin Adherence 80%**. Members who remained on a high statin medication of any intensity for at least 80% of the treatment period.

Statins (HMG CoA reductase inhibitors) are a class of drugs that lower blood cholesterol. Statins work in the liver by preventing the formation of cholesterol, thus lowering the amount of cholesterol in the blood.[1] Statins are most effective in lowering low-density lipoprotein cholesterol (LDL-C). The amount of cholesterol-lowering effect is based on statin intensity, which is classified as either high, moderate, or low.

This measure was added to the Texas Subset beginning with HEDIS® 2017.

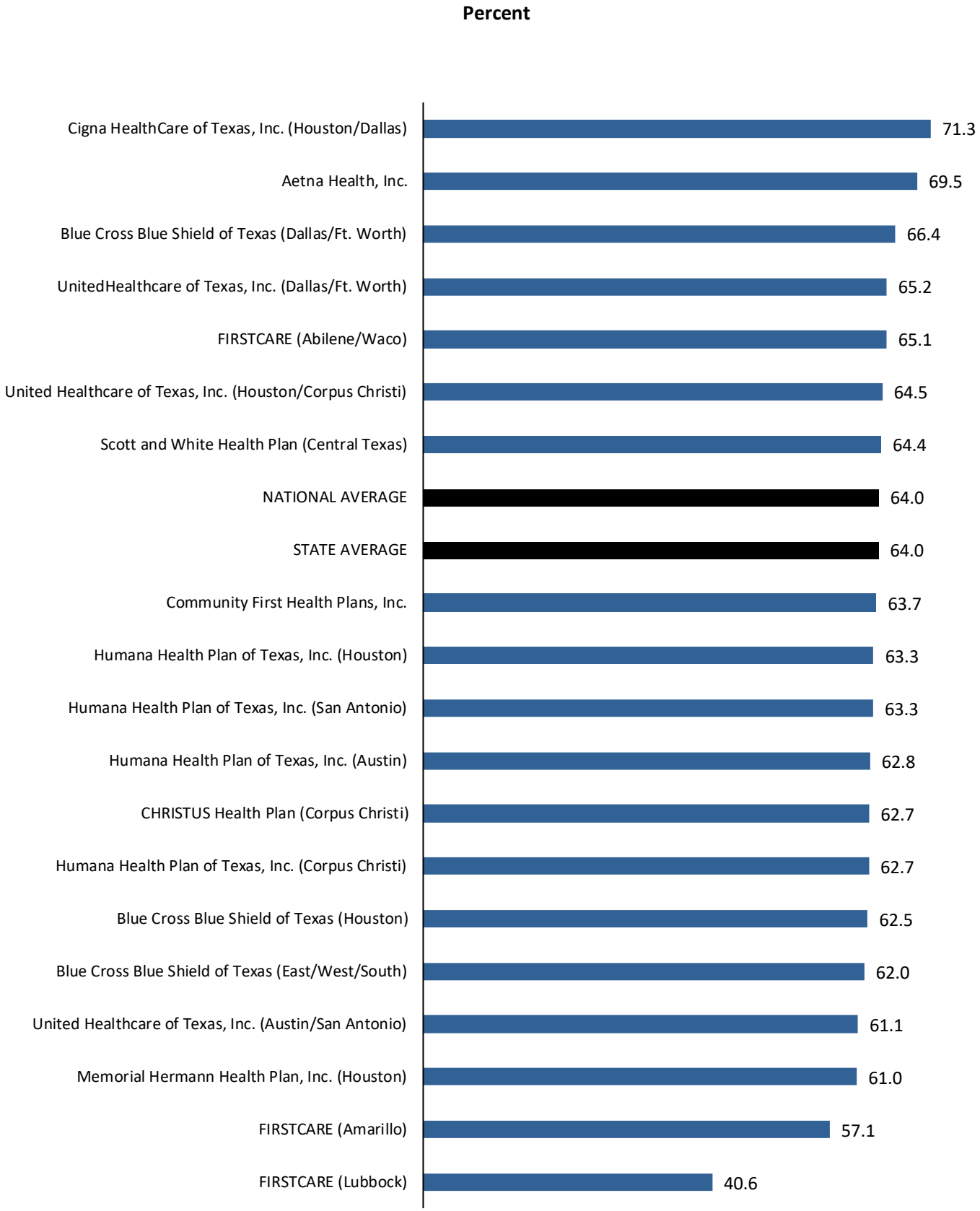
Statin Therapy for Patients with Diabetes: Total										
	2016		2017		2018		2019		2020	
	TX	QC	TX	QC	TX	QC	TX	QC	TX	QC
Received Statin Therapy	**	**	62.1%	**	59.1%	61.5%	62.2%	63.0%	64.0%	64.0%
Statin Adherence 80%	**	**	59.5%	**	60.4%	66.5%	64.0%	70.1%	66.3%	70.4%

Quality Compass® (QC) is a national database of health plan-specific performance information voluntarily reported to the NCQA.

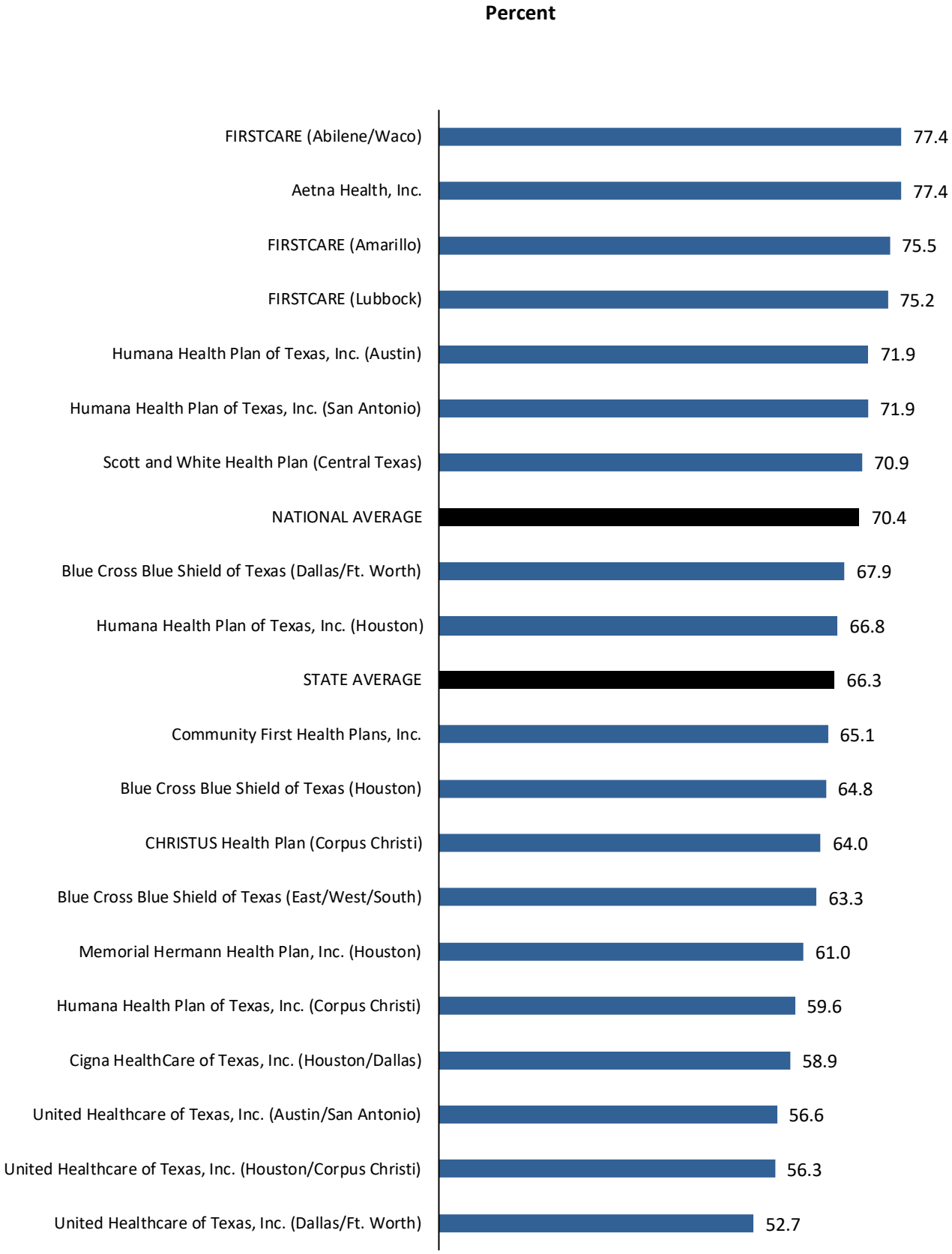
** Value not established or not obtained.

[1] American Heart Association (AHA). 2014. "Drug Therapy for Cholesterol." http://www.heart.org/HEARTORG/Conditions/Cholesterol/PreventionTreatmentofHighCholesterol/Drug-Therapy-for-Cholesterol_UCM

Received Statin Therapy



Statin Adherence 80%



Effectiveness of Care

Respiratory Conditions

Appropriate Testing for Children with Pharyngitis

DEFINITION:

The percentage of members 3-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode.

Pharyngitis (sore throat) can be caused by a virus or bacteria and a physician can definitively confirm the diagnosis with a lab test. Antibiotics can effectively treat diseases caused by bacteria, but most upper respiratory infections (URIs) are caused by viruses and cannot be treated with antibiotics.

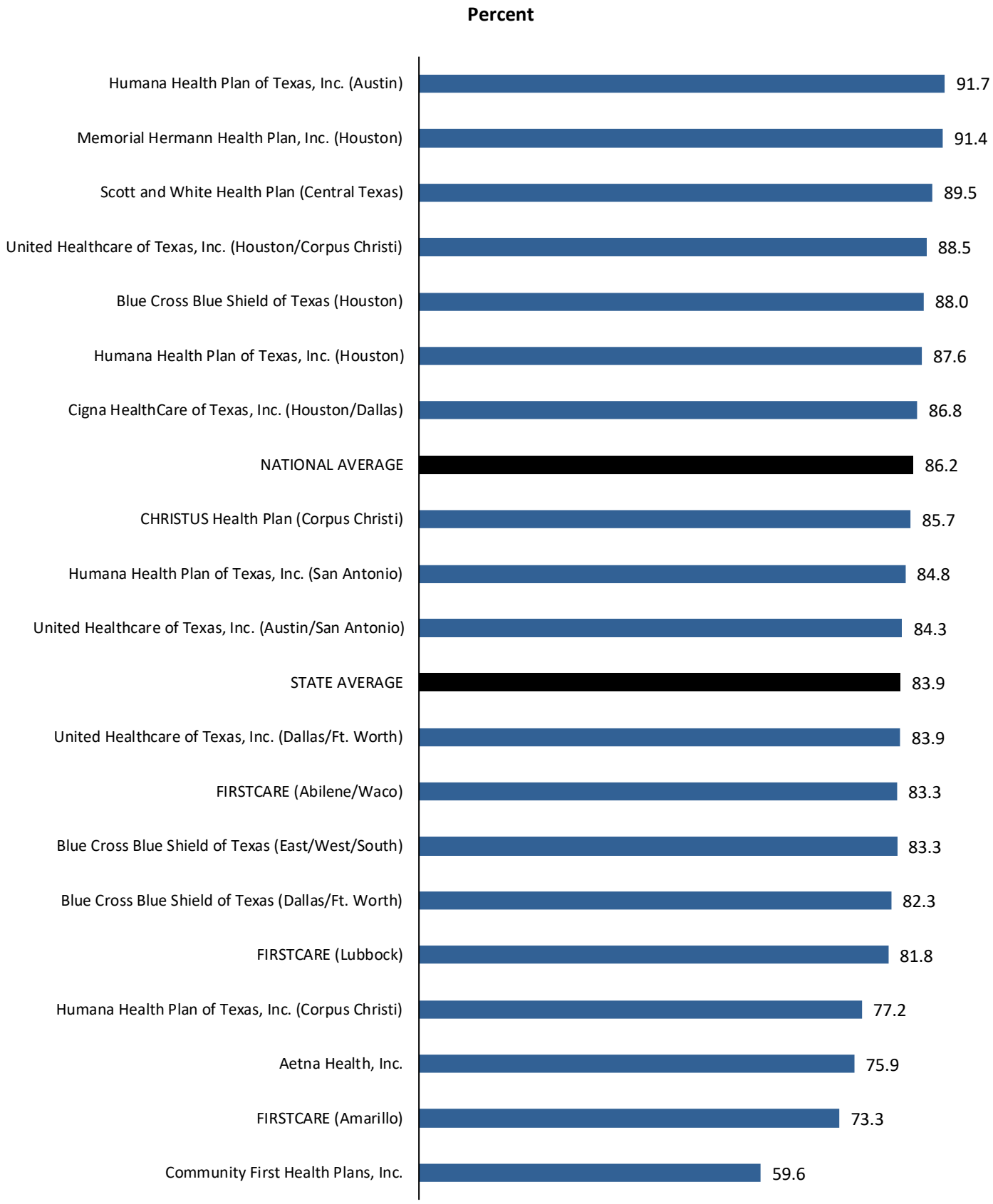
Antibiotic use to treat pharyngitis can serve as an important indicator of appropriate antibiotic use in children because pediatric clinical practice guidelines recommend only treating children diagnosed with group A streptococcus pharyngitis (strep throat) with antibiotics.[1]

Appropriate Testing for Children with Pharyngitis					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	77.5%	82.1%	82.6%	85.4%	83.9%
NCQA's Quality Compass®	82.8%	84.1%	86.8%	87.3%	86.2%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

[1] Centers for Disease Control and Prevention. "Office Related Antibiotic Prescribing for Persons Aged < 14 Years - United States, 1993-1994 to 2007-2008." *Morbidity and Mortality Weekly Report*. 60: 1153- 1156 (2011).

Appropriate Testing for Children with Pharyngitis



Appropriate Treatment for Children with Upper Respiratory Infection (URI)

DEFINITION:

The percentage of members 3 months to 18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription.

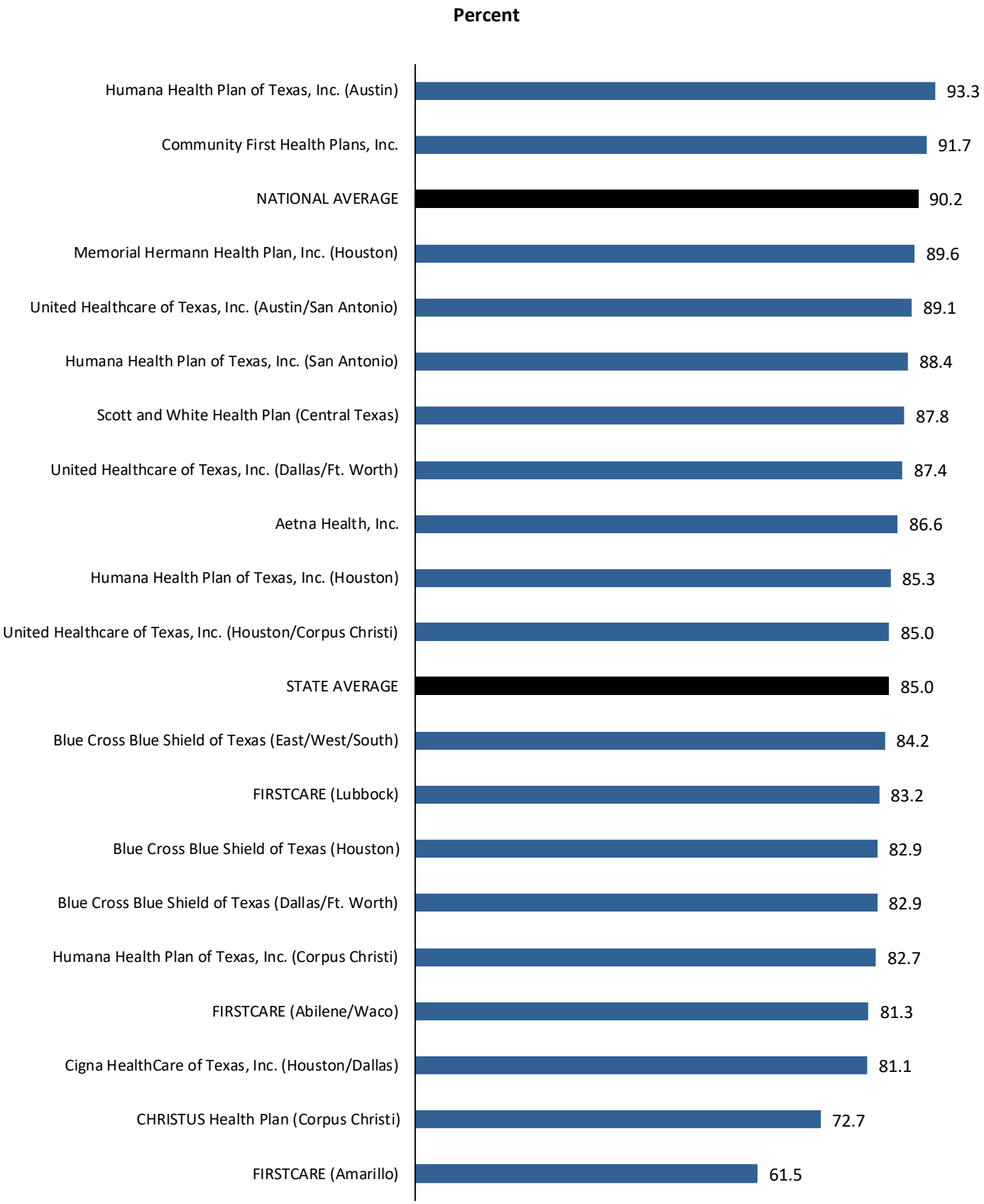
Antibiotics can effectively treat diseases caused by bacteria, but most **URIs** are caused by viruses and cannot be treated with antibiotics. However, some physicians still prescribe antibiotics for these conditions, including the common cold (non-specific URI).[1] The incidence of antibiotic use to treat a URI can serve as an important indicator of appropriate antibiotic use in children.

Appropriate Treatment for Children with URI					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	79.9%	83.4%	80.1%	84.6%	85.0%
NCQA's Quality Compass®	88.3%	88.4%	88.8%	90.8%	90.2%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

[1] Centers for Disease Control and Prevention. "Office Related Antibiotic Prescribing for Persons Aged < 14 Years - United States, 1993-1994 to 2007-2008." *Morbidity and Mortality Weekly Report*. 60: 1153- 1156 (2011).

Appropriate Treatment for Children with URI



Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

DEFINITION:

The percentage of members 18-64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.

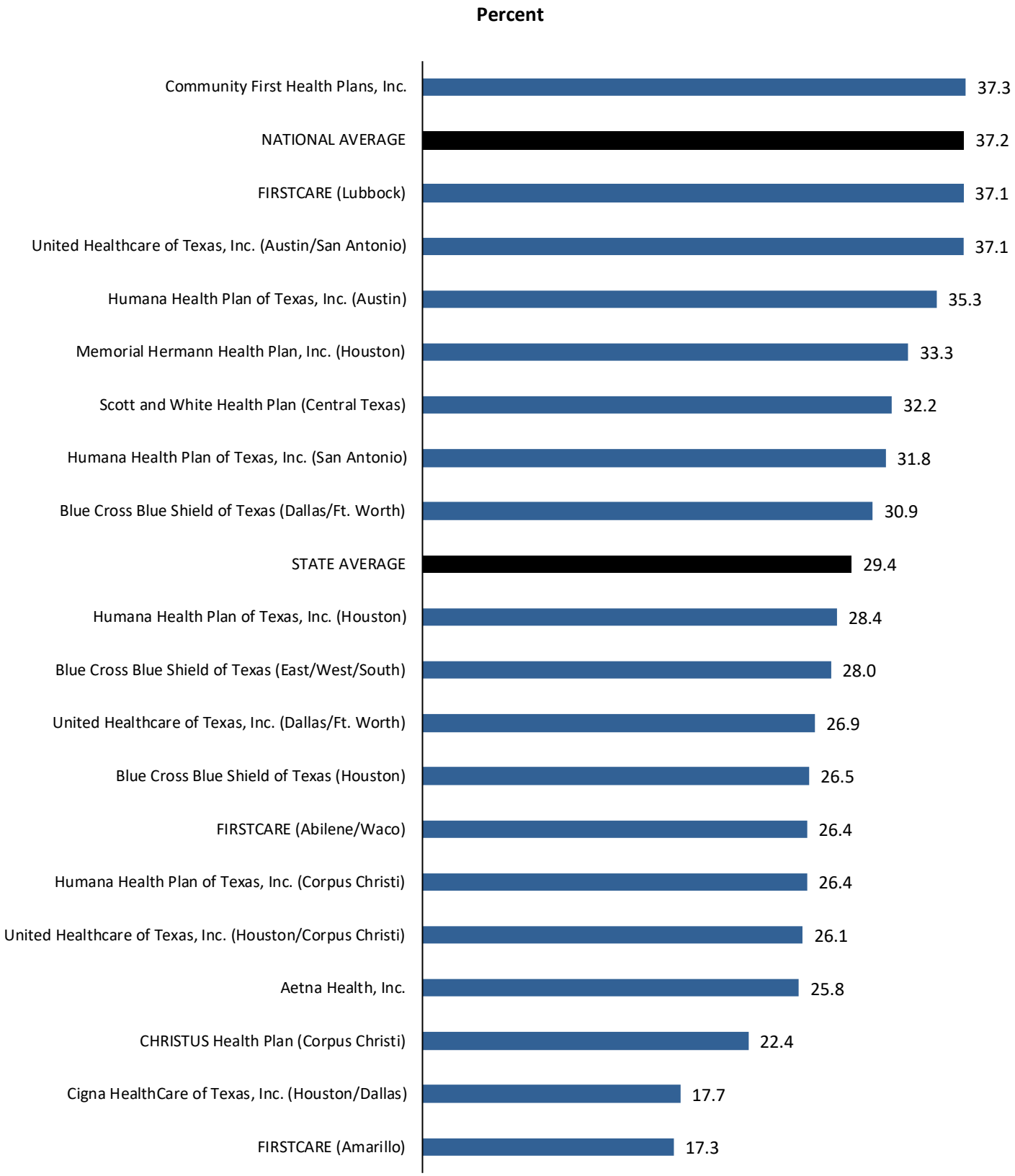
Acute bronchitis (chest cold) occurs when the bronchial tubes in the lungs become inflamed. The swelling often occurs after an upper respiratory illness like a cold. The symptoms include soreness in the chest, coughing, and low-grade fever. More than 90% of acute bronchitis cases are caused by a virus and should not be treated with an antibiotic.[1] The incidence of antibiotic use to treat acute bronchitis can serve as an important indicator of appropriate antibiotic use in adults.

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	19.2%	19.4%	24.8%	28.2%	29.4%
NCQA's Quality Compass®	27.7%	29.9%	32.0%	35.1%	37.2%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

[1] Centers for Disease Control and Prevention. *Acute Cough Illness (Acute Bronchitis): Physician Information Sheet (Adults).* Atlanta, GA: Centers for Disease Control and Prevention, 2015.

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis



Medication Management for People with Asthma: On Asthma Controller Medication for at Least 50% of Their Treatment Period

DEFINITION:

The percentage of members 5-65 years of age with persistent asthma who were dispensed appropriate medications and remained on an asthma controller medication for at least 50% of their treatment period.

Asthma is an obstructive lung disease caused by an increased reaction of the airways to various stimuli. Most individuals with asthma can manage the disease with long-term controller medications.

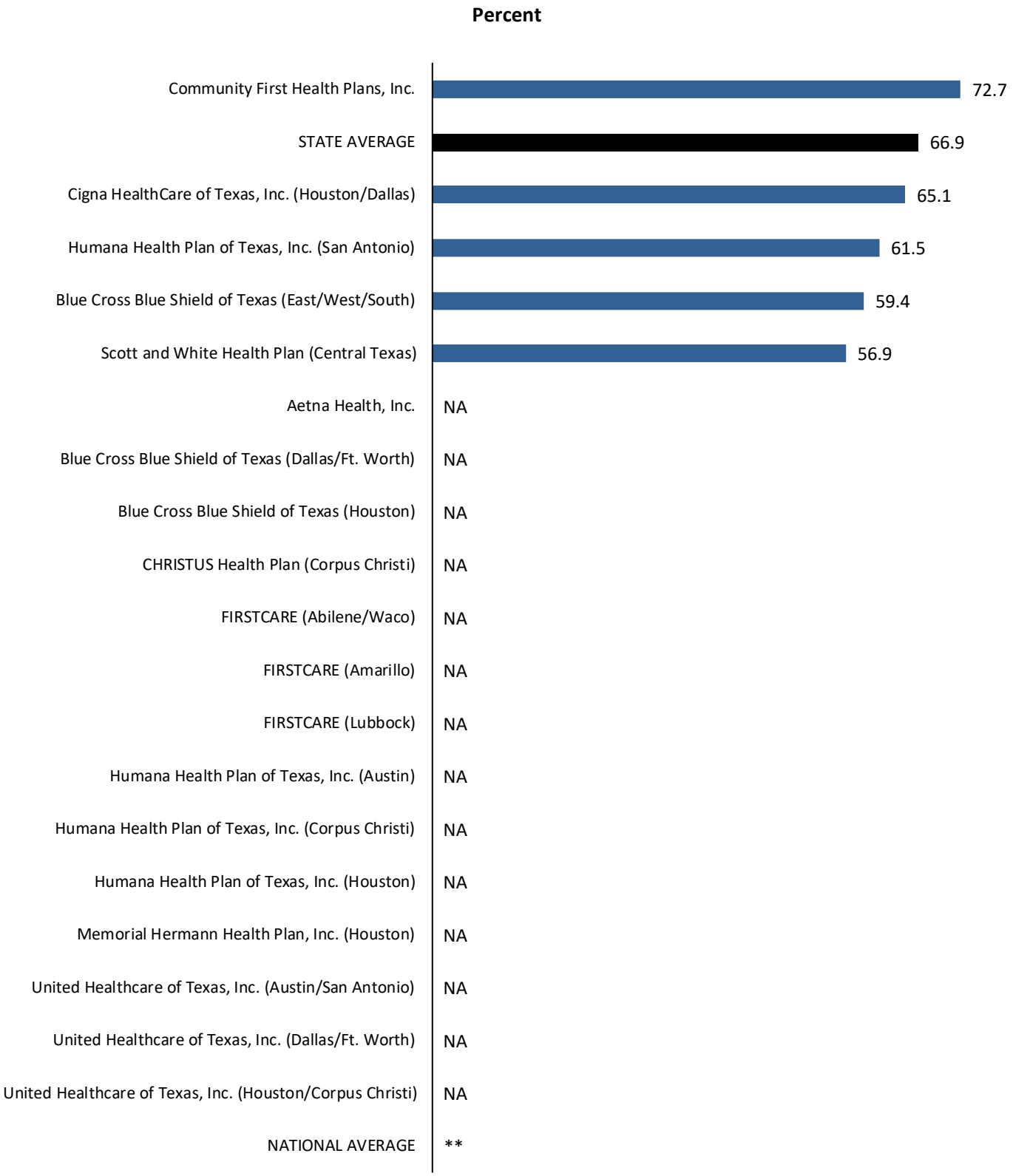
This section reports the use of appropriate medications for people with asthma in the following groups: ages 5-11, 12-18, 19-50, 51-64, and a combined rate for all ages.

On Asthma Controller Medication for at Least 50% of Their Treatment Period: Total					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	69.8%	68.3%	71.8%	73.3%	74.4%
NCQA's Quality Compass®	**	**	**	**	**

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

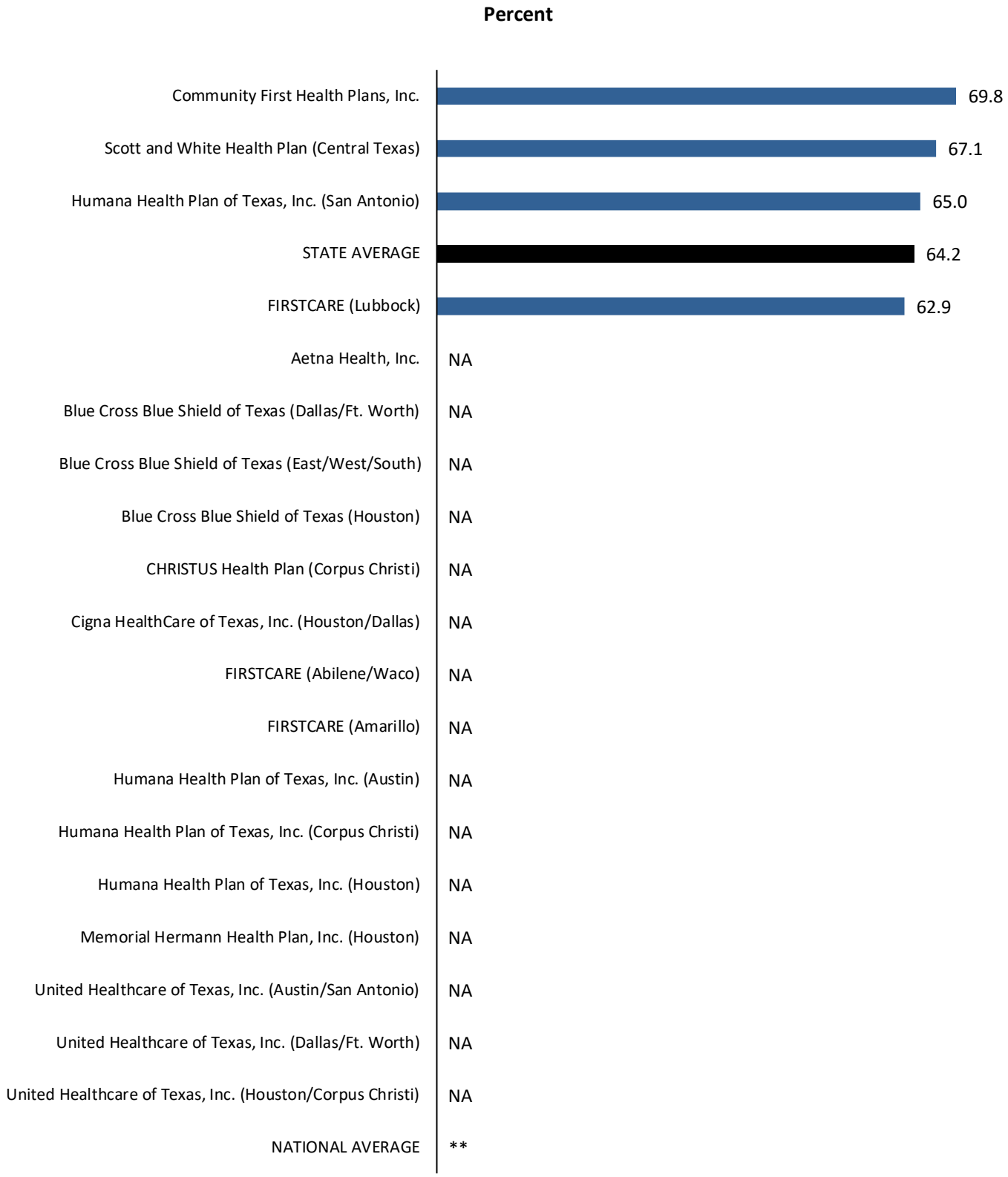
** Value not established or not obtained.

On Asthma Controller Medication for at Least 50% of Their Treatment Period: Age 5-11



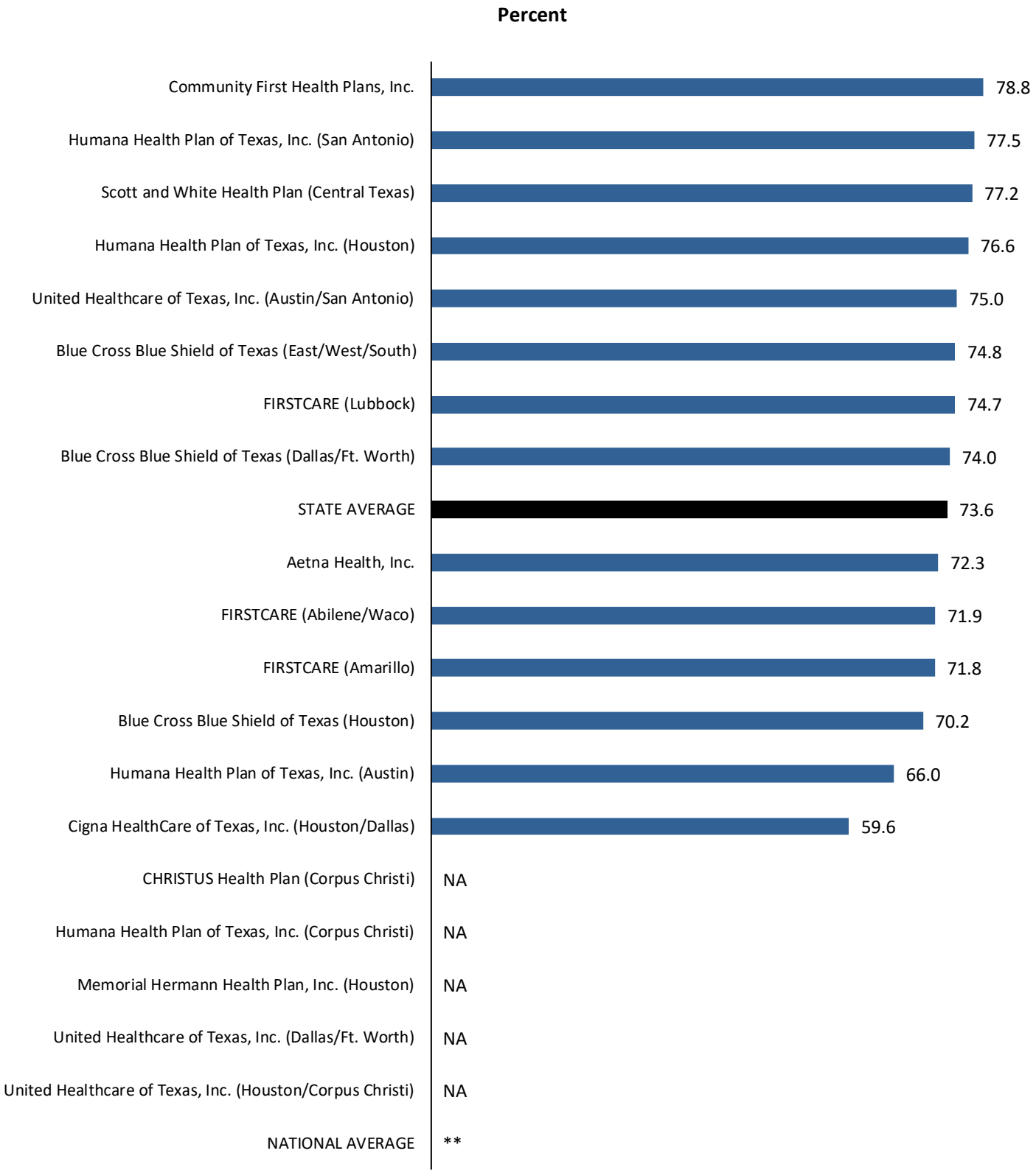
NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.
*** Value not established or obtained.*

On Asthma Controller Medication for at Least 50% of Their Treatment Period: Age 12-18



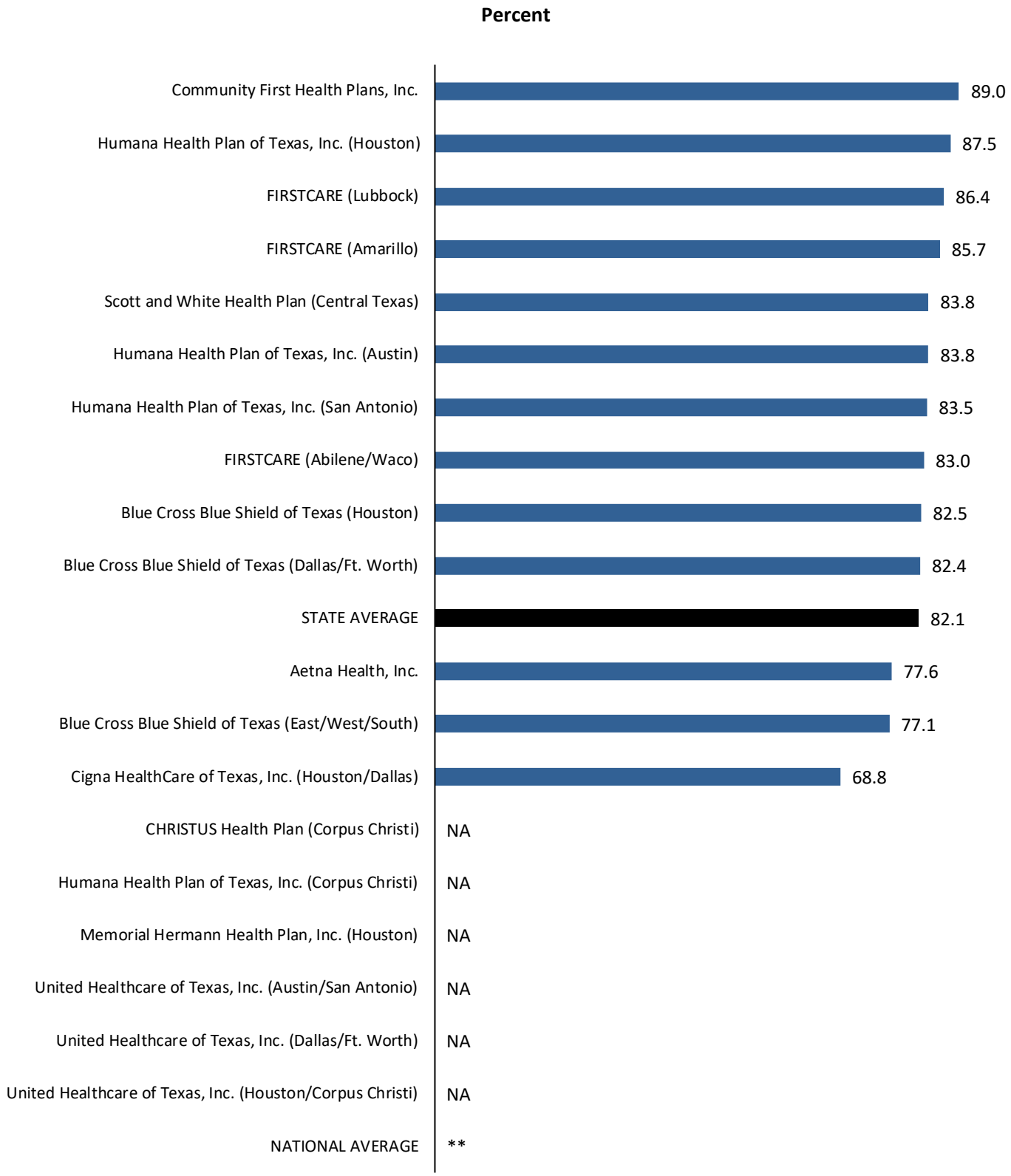
NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.
*** Value not established or obtained.*

On Asthma Controller Medication for at Least 50% of Their Treatment Period: Age 19-50



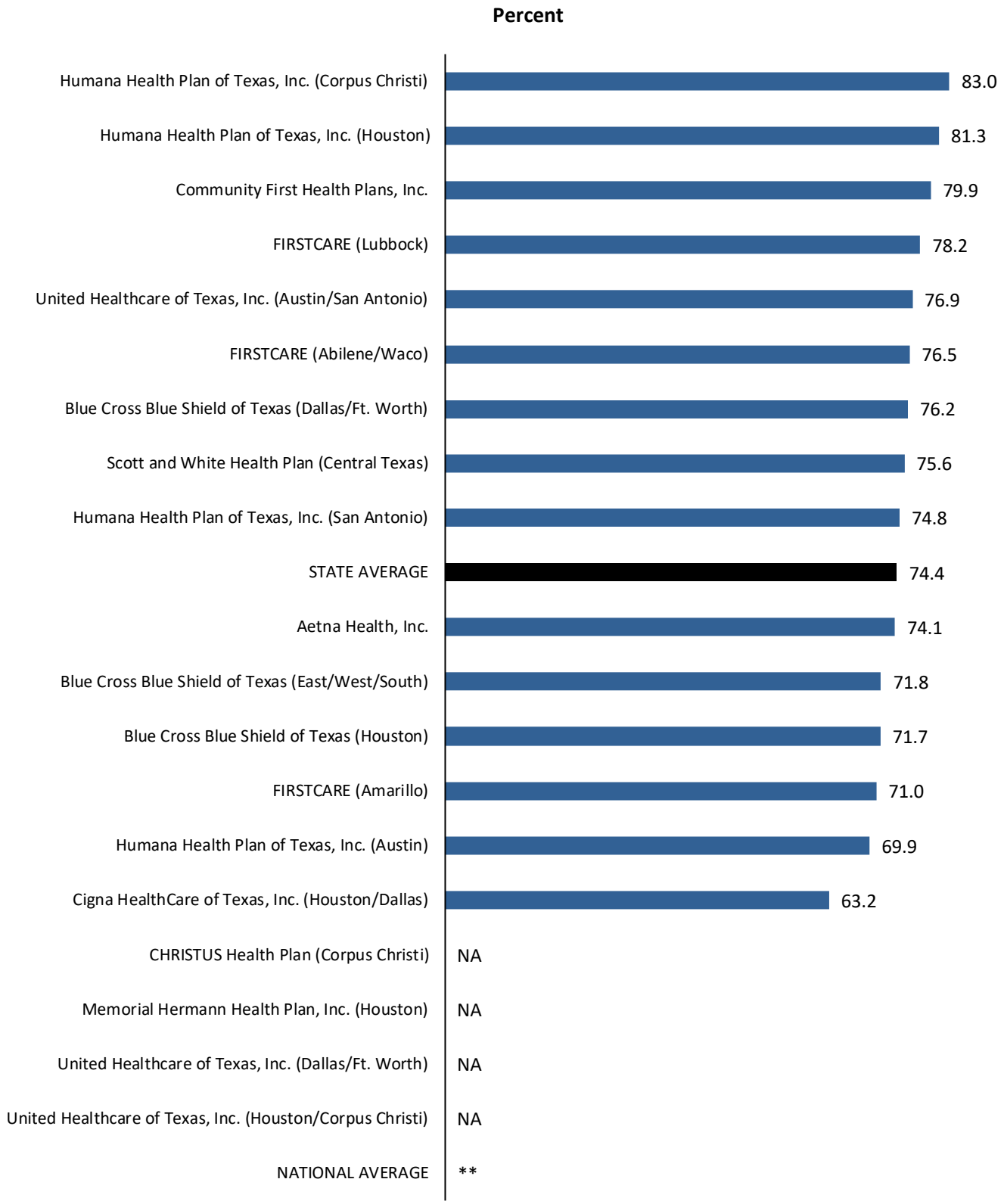
NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.
*** Value not established or obtained.*

On Asthma Controller Medication for at Least 50% of Their Treatment Period: Age 51-64



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.
*** Value not established or obtained.*

On Asthma Controller Medication for at Least 50% of Their Treatment Period: Total



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.
*** Value not established or obtained.*

Medication Management for People with Asthma: On Asthma Controller Medication for at Least 75% of Their Treatment Period

DEFINITION:

The percentage of members 5-65 years of age with persistent asthma who were dispensed appropriate medications and remained on an asthma controller medication for at least 75% of their treatment period.

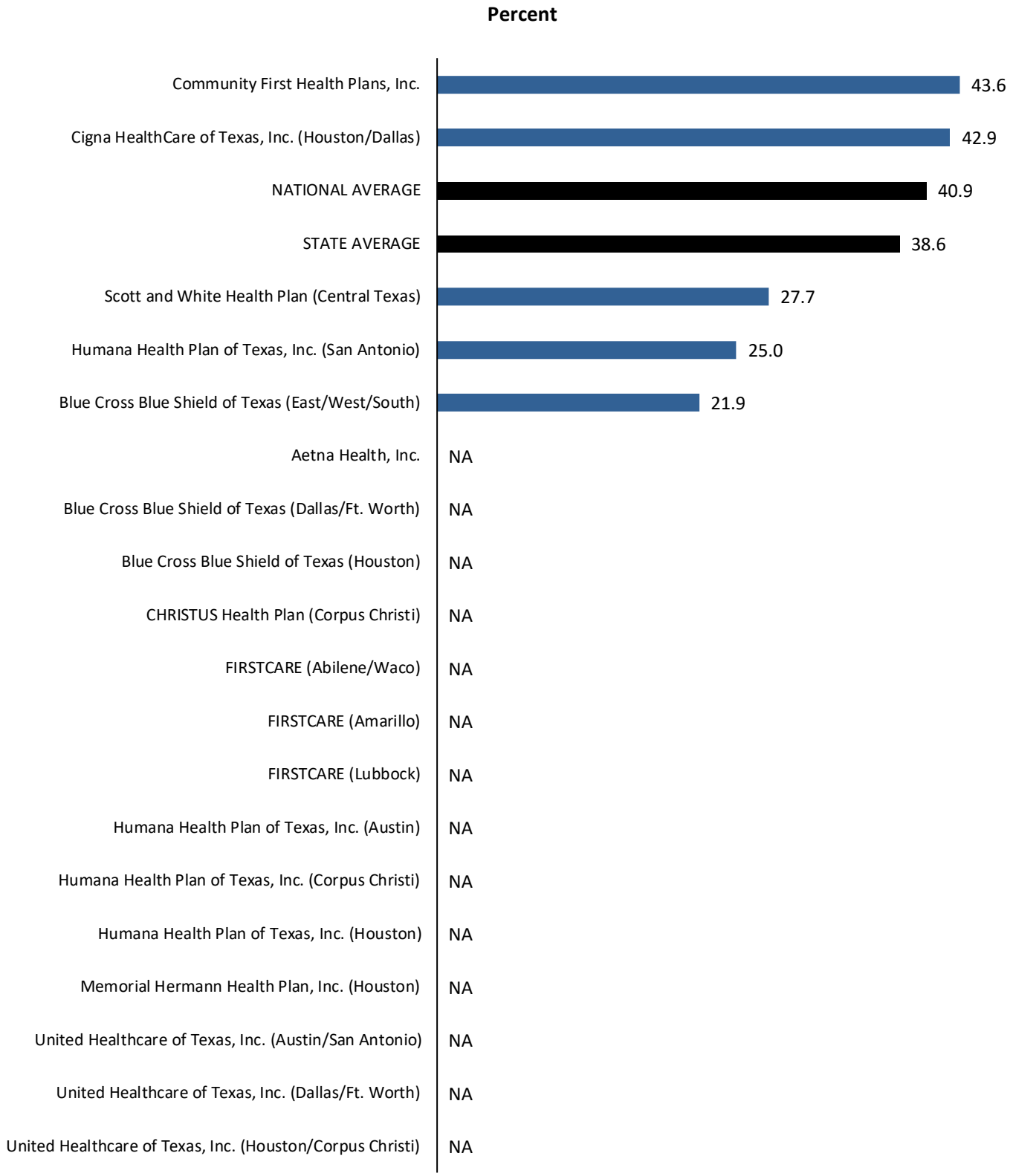
Asthma is an obstructive lung disease caused by an increased reaction of the airways to various stimuli. Most individuals with asthma can manage the disease with long-term controller medications.

This section reports the use of appropriate medications for people with asthma in the following groups: ages 5-11, 12-18, 19-50, 51-64, and a combined rate for all ages.

On Asthma Controller Medication for at Least 75% of Their Treatment Period: Total					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	46.3%	44.8%	46.7%	48.3%	52.3%
NCQA's Quality Compass®	46.3%	48.5%	50.3%	51.8%	53.4%

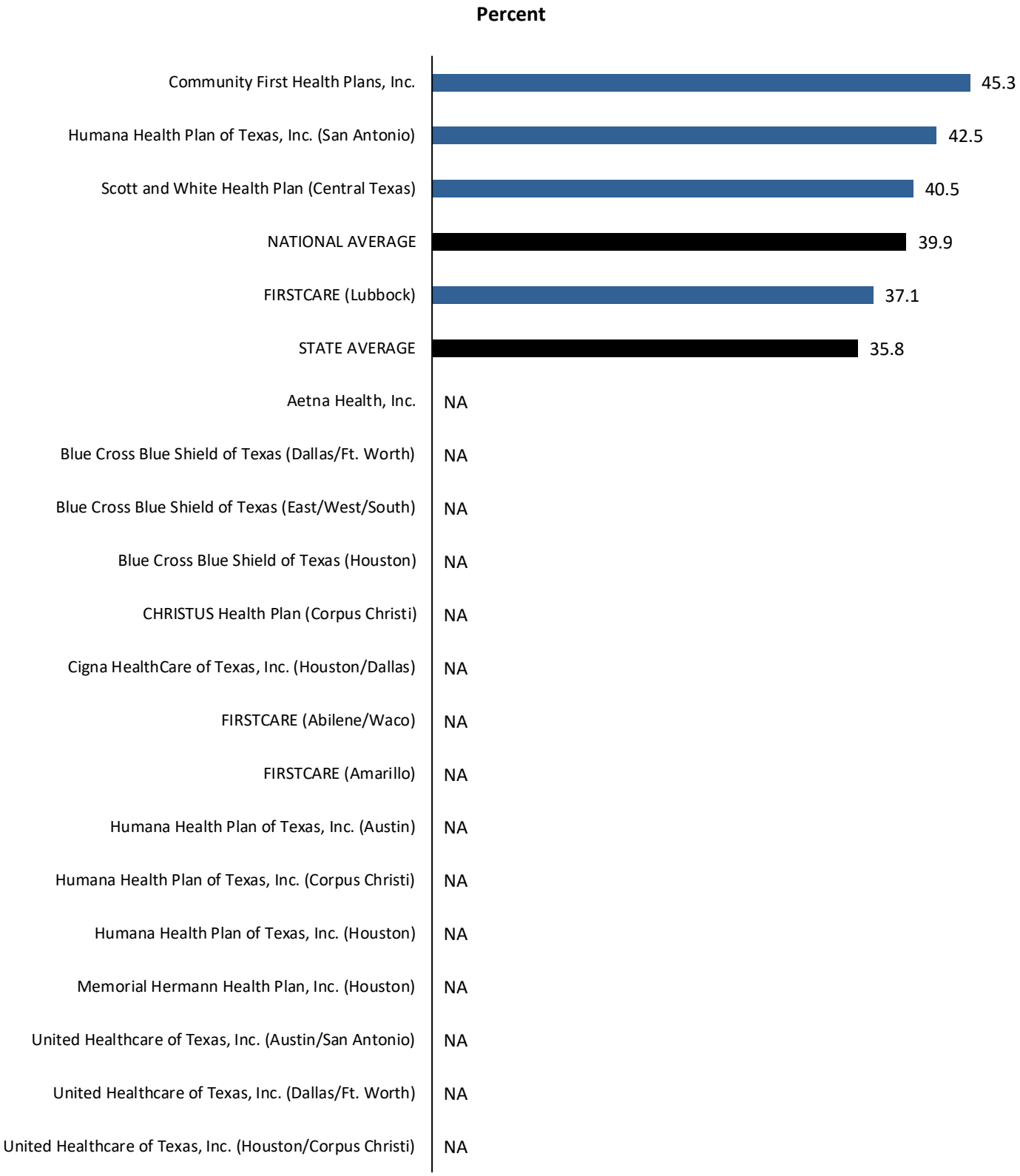
Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

On Asthma Controller Medication for at Least 75% of Their Treatment Period: Age 5-11



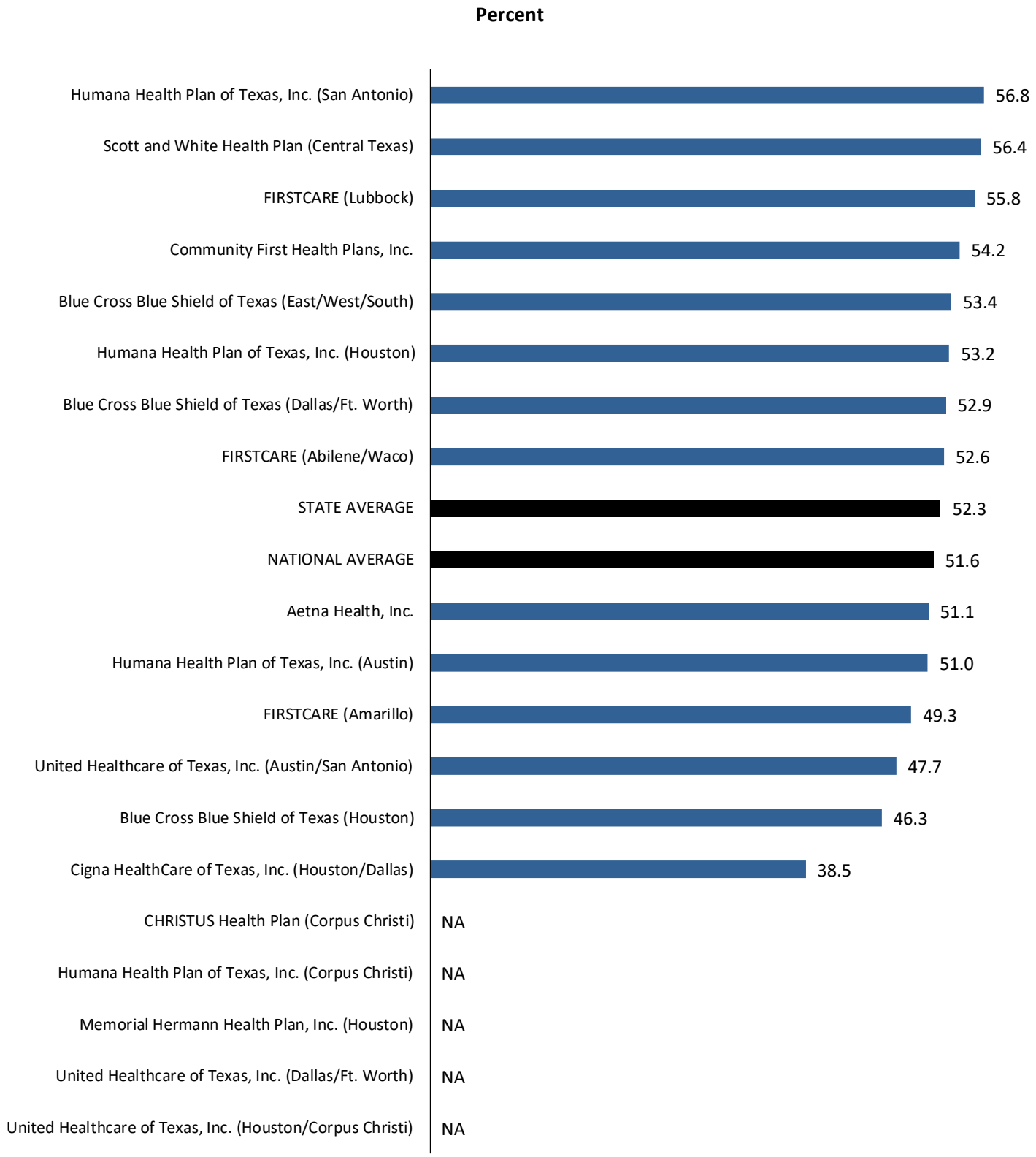
NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

On Asthma Controller Medication for at Least 75% of Their Treatment Period: Age 12-18



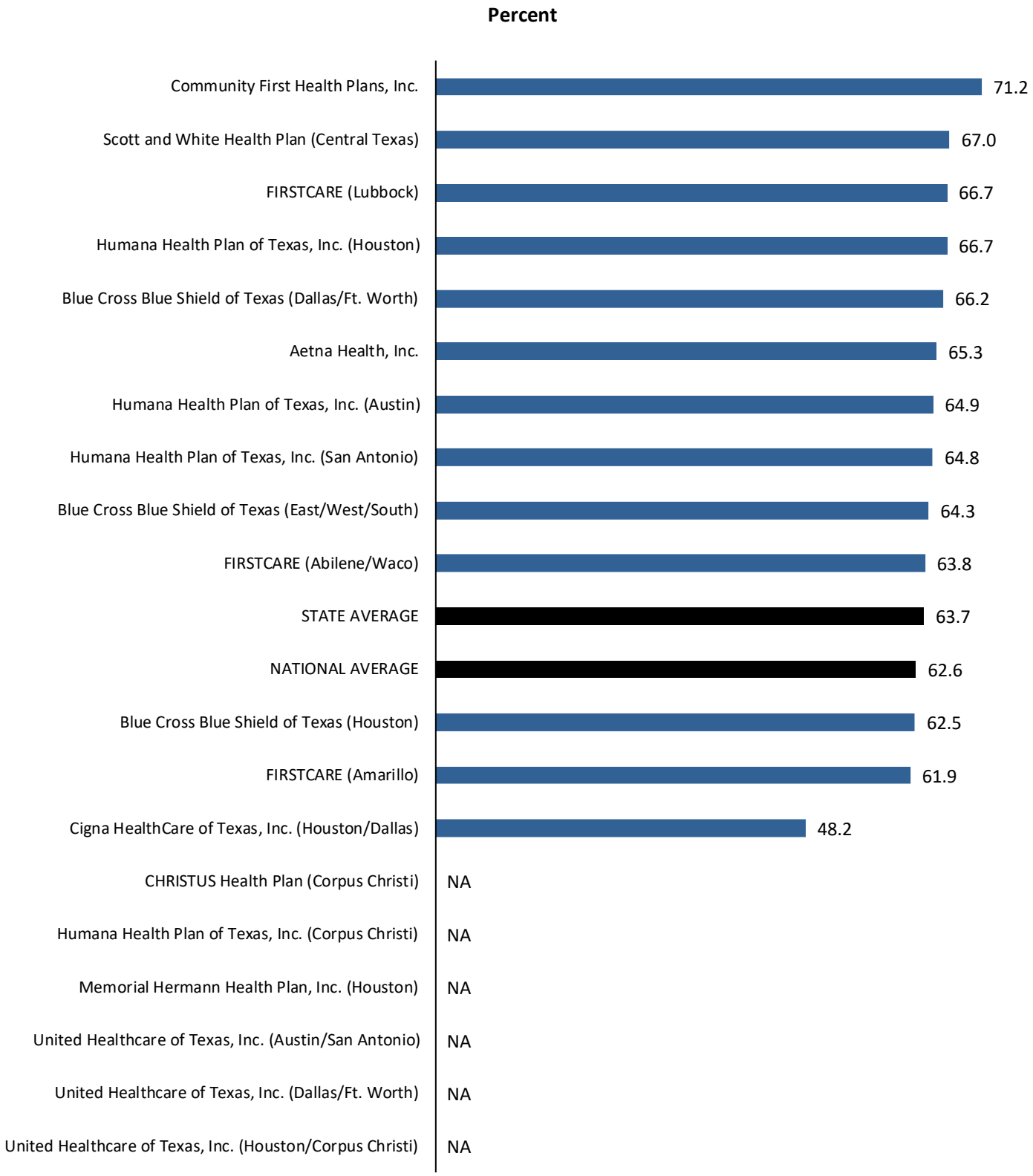
NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

On Asthma Controller Medication for at Least 75% of Their Treatment Period: Age 19-50



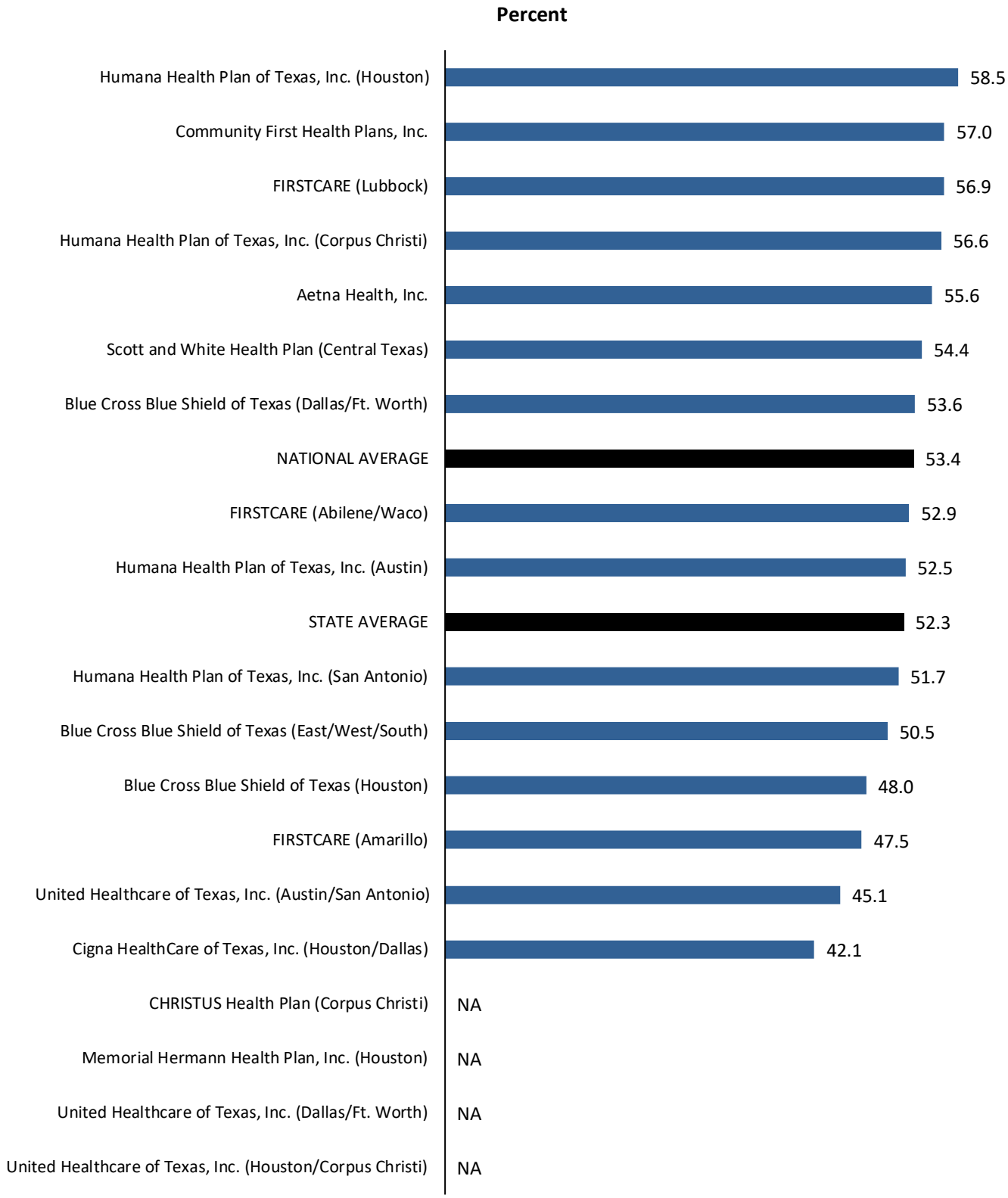
NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

On Asthma Controller Medication for at Least 75% of Their Treatment Period: Age 51-64



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

On Asthma Controller Medication for at Least 75% of Their Treatment Period: Total



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Effectiveness of Care

Behavioral Health

Antidepressant Medication Management: Effective Acute Phase Treatment

DEFINITION:

The percentage of members 18 or older who were diagnosed with major depression, treated with antidepressant medication, and who remained on an antidepressant medication during the entire 84-day (12-week) Acute Phase Treatment.

Major depressive disorder is characterized by a combination of symptoms that interfere with an individual's ability to work, sleep, study, and enjoy once-pleasurable activities. Some individuals experience only 1 episode within a lifetime, others experience multiple episodes.

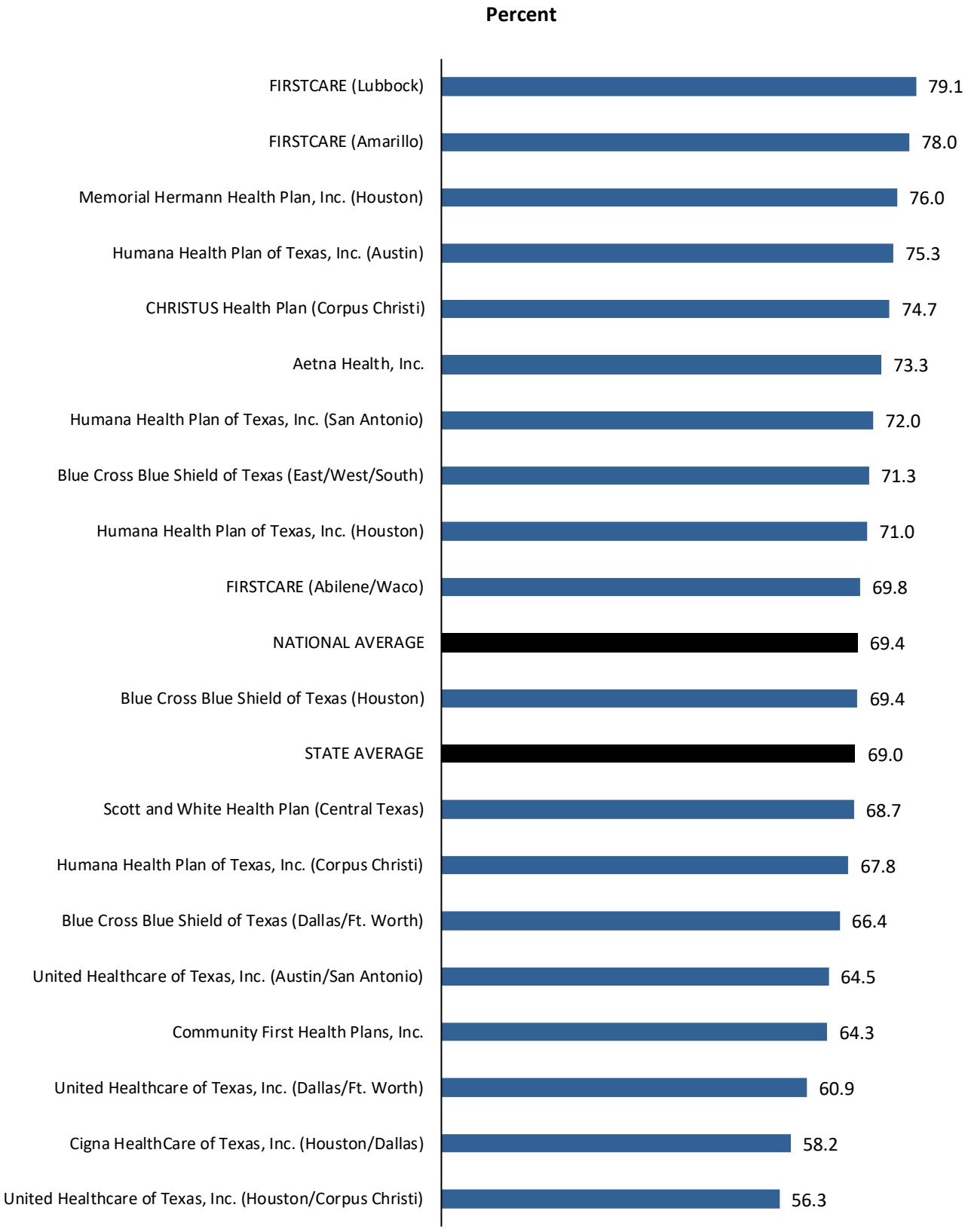
The American Psychiatric Association (APA) contends that a thorough assessment of the patient and close adherence to treatment plans promotes successful treatment of patients with major depressive disorder.[1] Antidepressant medications are often prescribed to individuals diagnosed with major depressive disorder as a part of a comprehensive treatment plan.[2]

Antidepressant Medication Management: Effective Acute Phase Treatment					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	64.3%	63.0%	63.8%	66.0%	69.0%
NCQA's Quality Compass®	66.4%	67.2%	67.8%	69.2%	69.4%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

[1] National Institute of Mental Health. *Health Topics: Depression*. Washington, D.C.: National Institutes of Health, 2016.
[2] American Psychiatric Association. *Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2006*. Arlington, VA: American Psychiatric Association, 2006.

Antidepressant Medication Management: Effective Acute Phase Treatment



Antidepressant Medication Management: Effective Continuation Phase Treatment

DEFINITION:

The percentage of members 18 or older who were diagnosed with major depression, treated with antidepressant medication, and who remained on an antidepressant medication for at least 180 days (6 months).

Major depressive disorder is characterized by a combination of symptoms that interfere with an individual's ability to work, sleep, study, and enjoy once-pleasurable activities. Some individuals experience only 1 episode within a lifetime, others experience multiple episodes.

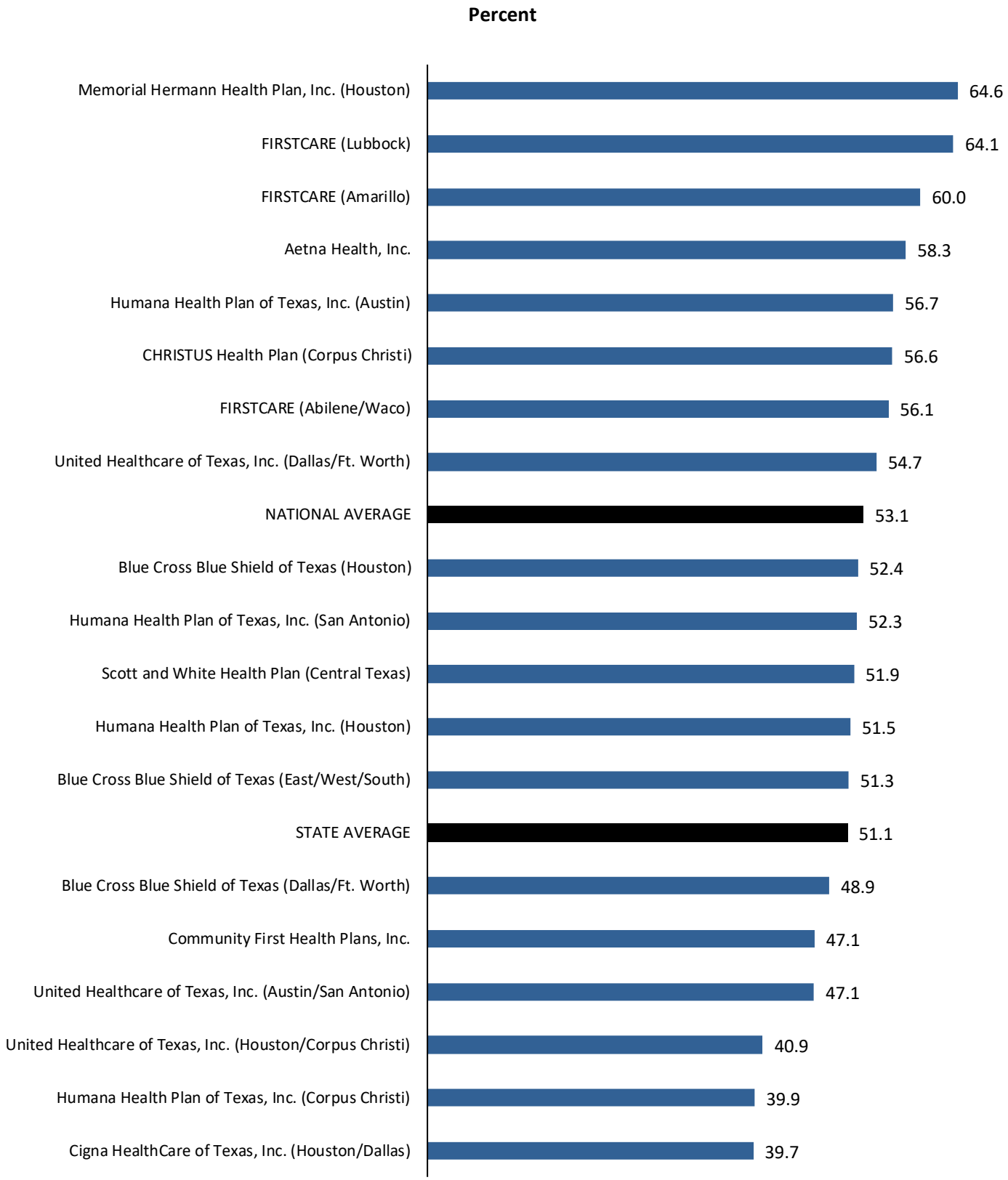
The American Psychiatric Association (APA) contends that a thorough assessment of the patient and close adherence to treatment plans promotes successful treatment of patients with major depressive disorder.[1] Antidepressant medications are often prescribed to individuals diagnosed with major depressive disorder as a part of a comprehensive treatment plan.[2]

Antidepressant Medication Management: Effective Continuation Phase Treatment					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	48.9%	46.3%	45.9%	49.8%	51.1%
NCQA's Quality Compass®	50.3%	50.9%	51.8%	52.9%	53.1%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

[1] National Institute of Mental Health. *Health Topics: Depression*. Washington, D.C.: National Institutes of Health, 2016.
[2] American Psychiatric Association. *Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2006*. Arlington, VA: American Psychiatric Association, 2006.

Antidepressant Medication Management: Effective Continuation Phase Treatment



Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase

DEFINITION:

The percentage of children, 6-12 years of age, newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least 1 follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.

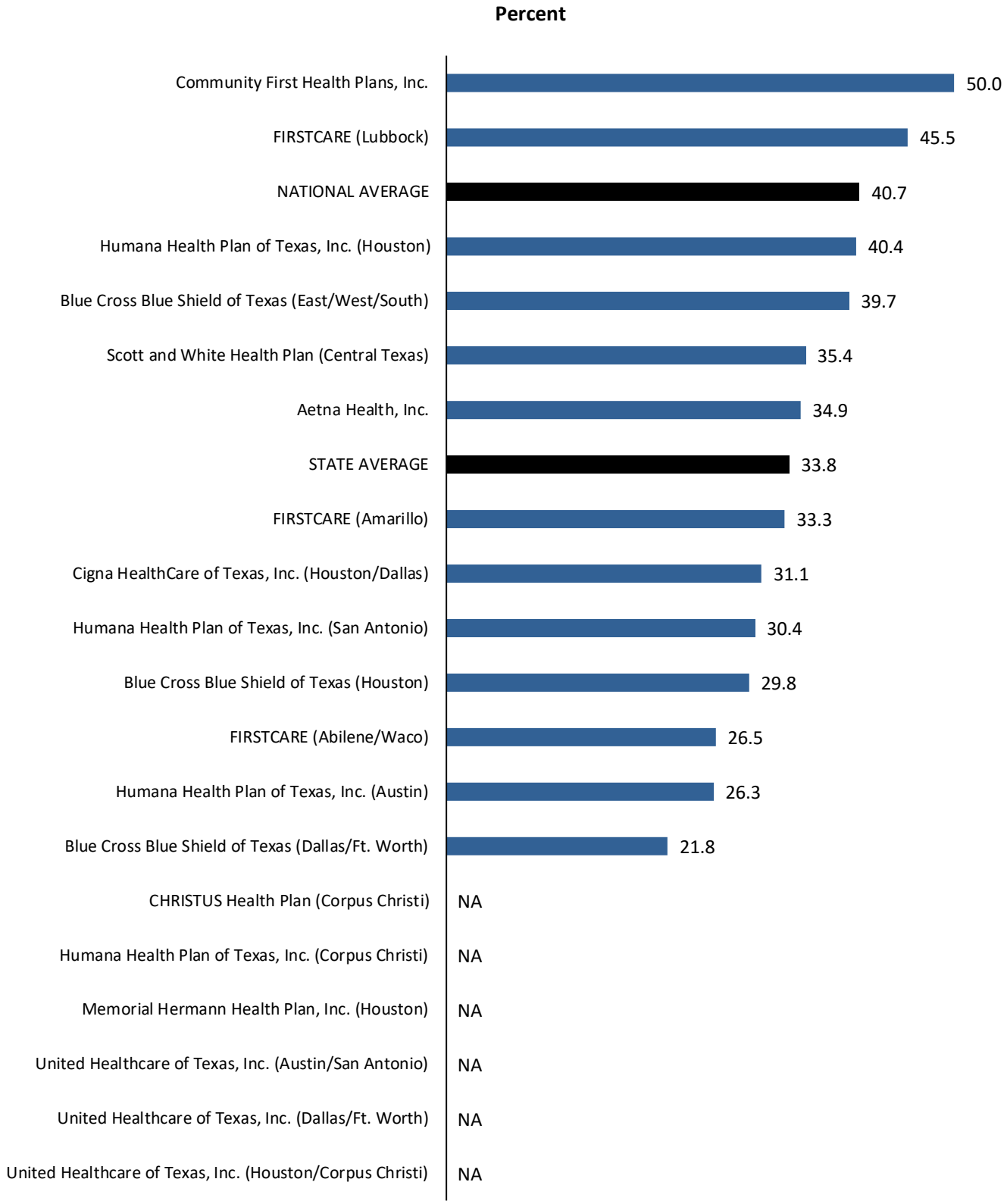
ADHD is a condition that can cause children to experience significant functional problems such as school difficulties, strained relationships with family members and peers, and behavioral problems.[1] The American Academy of Pediatrics (AAP) guidelines recommend that a child receive follow-up appointments at least once a month until the symptoms have stabilized. After that, the child should have an office visit once every 3-6 months to assess learning and behavior.[2]

Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	31.9%	33.1%	32.7%	30.8%	33.8%
NCQA's Quality Compass®	39.4%	40.0%	41.7%	40.6%	40.7%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

[1] American Academy of Pediatrics. *Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents*. Pediatrics. 128(5): 1007-22 (2011).
[2] Ibid.

Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase

DEFINITION:

The percentage of children, 6-12 years of age, newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least 2 follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

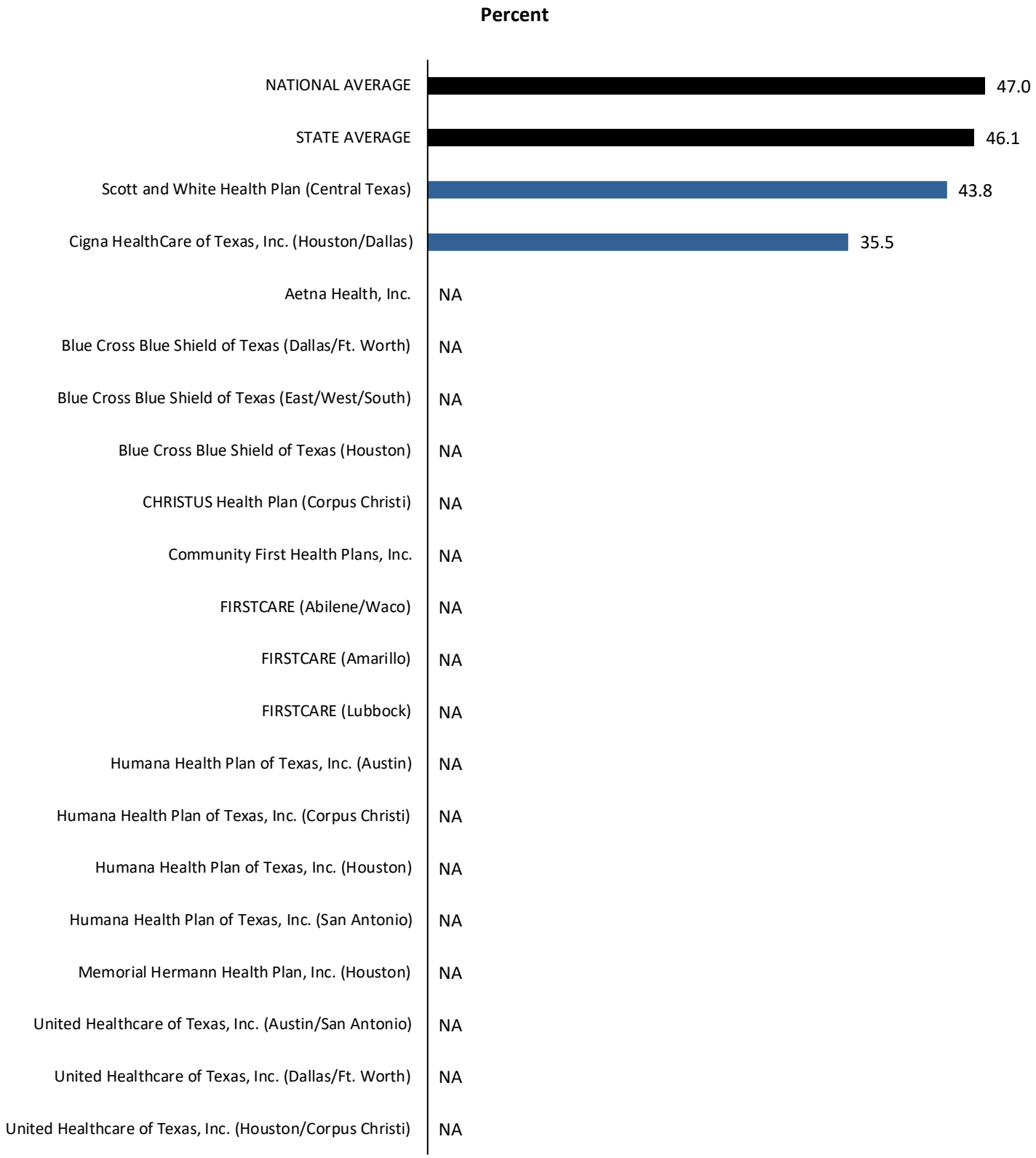
ADHD is a condition that can cause children to experience significant functional problems such as school difficulties, strained relationships with family members and peers, and behavioral problems.[1] The American Academy of Pediatrics (AAP) guidelines recommend that a child receive follow-up appointments at least once a month until the symptoms have stabilized. After that, the child should have an office visit once every 3-6 months to assess learning and behavior.[2]

Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	36.5%	39.7%	40.0%	42.6%	46.1%
NCQA's Quality Compass®	47.7%	46.5%	48.2%	49.7%	47.0%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

[1] American Academy of Pediatrics. *Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents*. Pediatrics. 128(5): 1007-22 (2011).
[2] Ibid.

Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Follow-Up After Hospitalization for Mental Illness

DEFINITION:

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had one of the following follow-up services: 1) an outpatient visit with a mental health practitioner; 2) an intensive outpatient encounter; or 3) partial hospitalization. The measure reports the percentage of members who received follow-up care within 7 days of discharge and 30 days of discharge.

Individuals who have follow-up services after an inpatient hospitalization for mental illness are less likely to be readmitted and more likely to make a successful transition back to home and work. Follow-up visits also help healthcare providers provide effective continuation of care. The American Psychiatric Association (APA)[1] and the American Academy of Child and Adolescent Psychiatry (AACAP)[2] both encourage timely follow-up services.

Follow-Up After Hospitalization for Mental Illness: Total

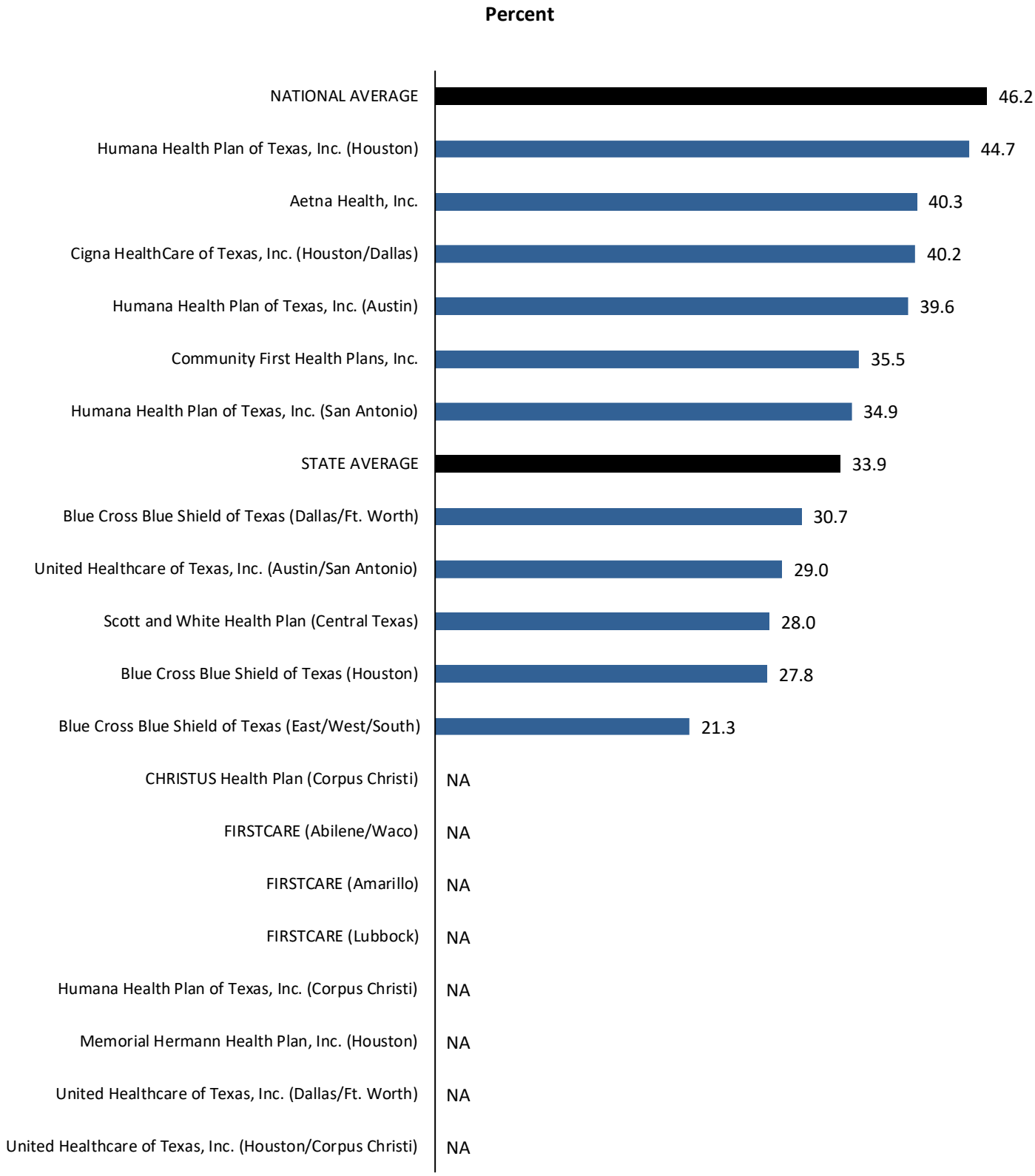
	2016		2017		2018		2019		2020	
	TX	QC	TX	QC	TX	QC	TX	QC	TX	QC
Within 7 Days	37.5%	52.2%	41.5%	52.9%	35.9%	48.2%	35.6%	45.6%	33.9%	46.2%
Within 30 Days	57.9%	70.8%	62.2%	72.0%	58.1%	69.7%	56.9%	66.6%	55.5%	67.8%

Quality Compass® (QC) is a national database of health plan-specific performance information voluntarily reported to the NCQA.

[1] American Psychiatric Association. *Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2006*. Arlington, VA: American Psychiatric Association, 2006.

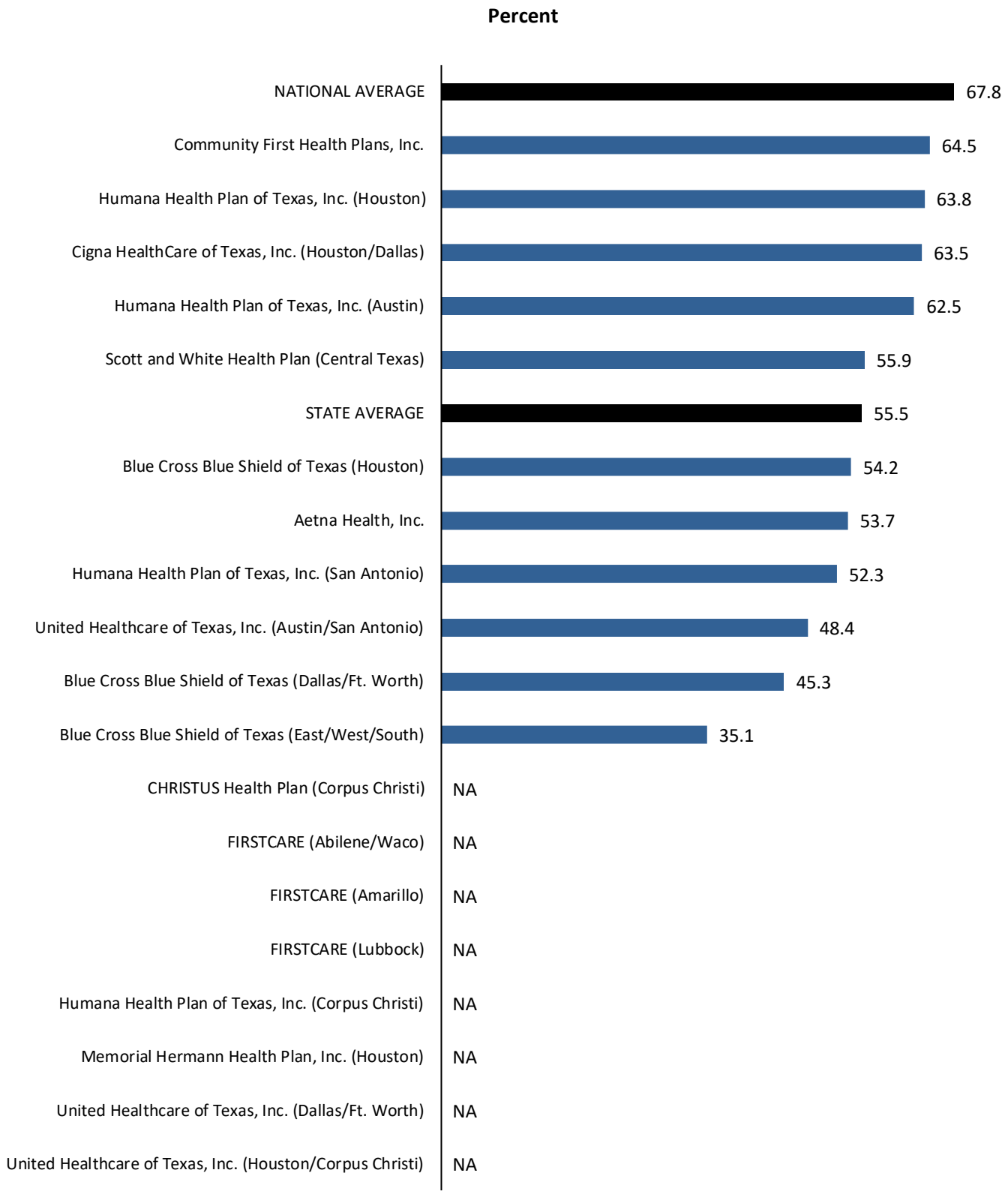
[2] American Academy of Child and Adolescent Psychiatry. *Policy Statement: Inpatient Hospital Treatment of Children and Adolescents*. Washington, D.C.: American Academy of Child and Adolescent Psychiatry, 1989.

Follow-Up Hospitalization for Mental Illness: 7-Day Follow-Up



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Follow-Up After Hospitalization For Mental Illness: 30-Day Follow-Up



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Follow-Up After Emergency Department Visit for Mental Illness

DEFINITION:

This measure assesses the percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness, who had a follow-up visit for mental illness. Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Although ED visits are common among patients suffering from mental illness, many may be avoidable. Research suggests that for people with a serious mental illness, both low-intensity interventions, such as appointment reminders, and high-intensity interventions, such as assertive community treatment, can be effective following an ED visit, to encourage follow-up care in the outpatient setting.[1]

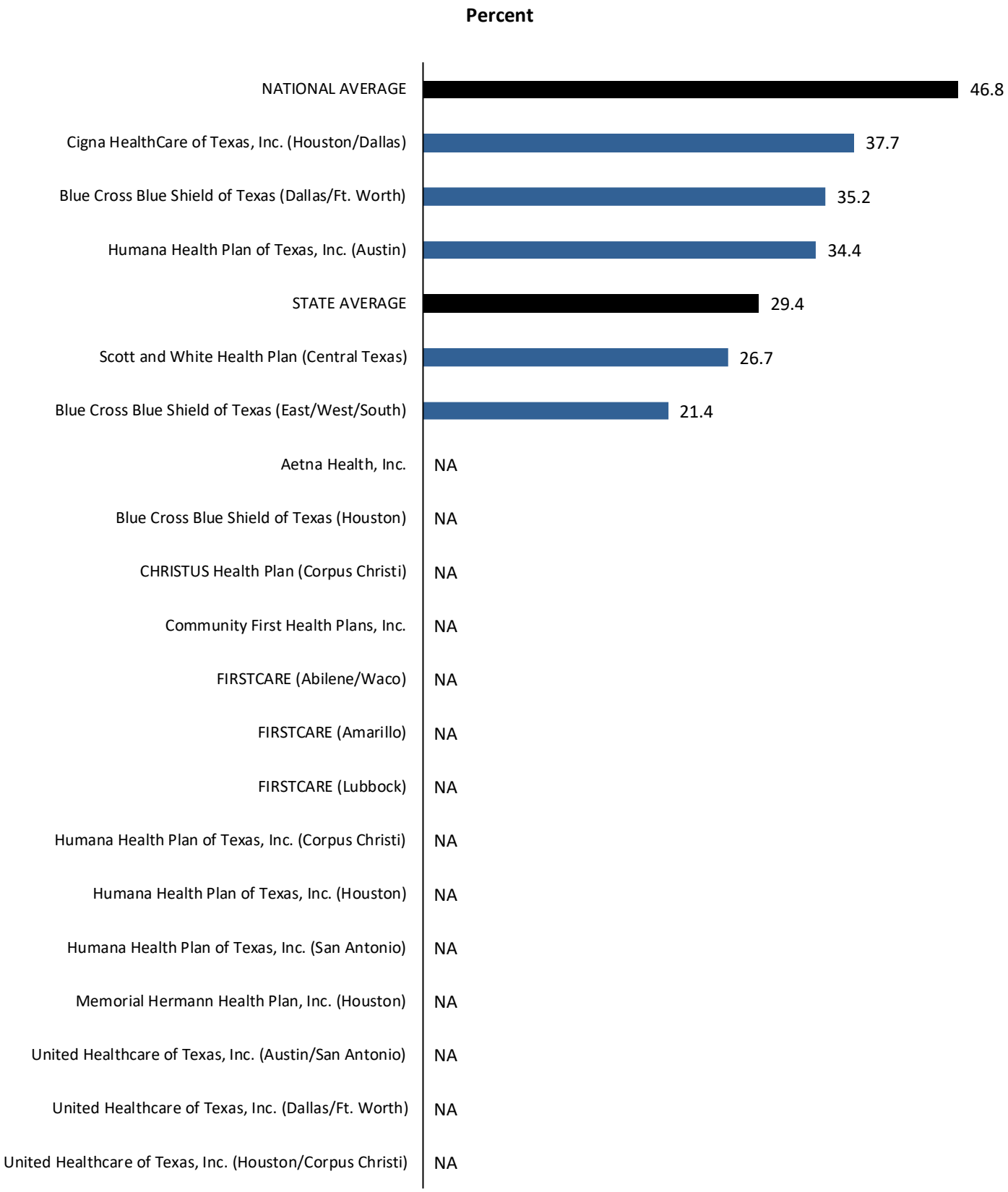
This measure was added to the Texas Subset beginning with HEDIS® 2018.

Follow-Up After ED Visit for Mental Illness: Total										
	2016		2017		2018		2019		2020	
	TX	QC	TX	QC	TX	QC	TX	QC	TX	QC
7 Days	**	**	**	**	29.0%	45.9%	33.0%	45.6%	29.4%	46.8%
30 Days	**	**	**	**	43.6%	60.2%	43.8%	60.2%	42.3%	61.2%

Quality Compass® (QC) is a national database of health plan-specific performance information voluntarily reported to the NCQA.
**Value not established or not obtained.

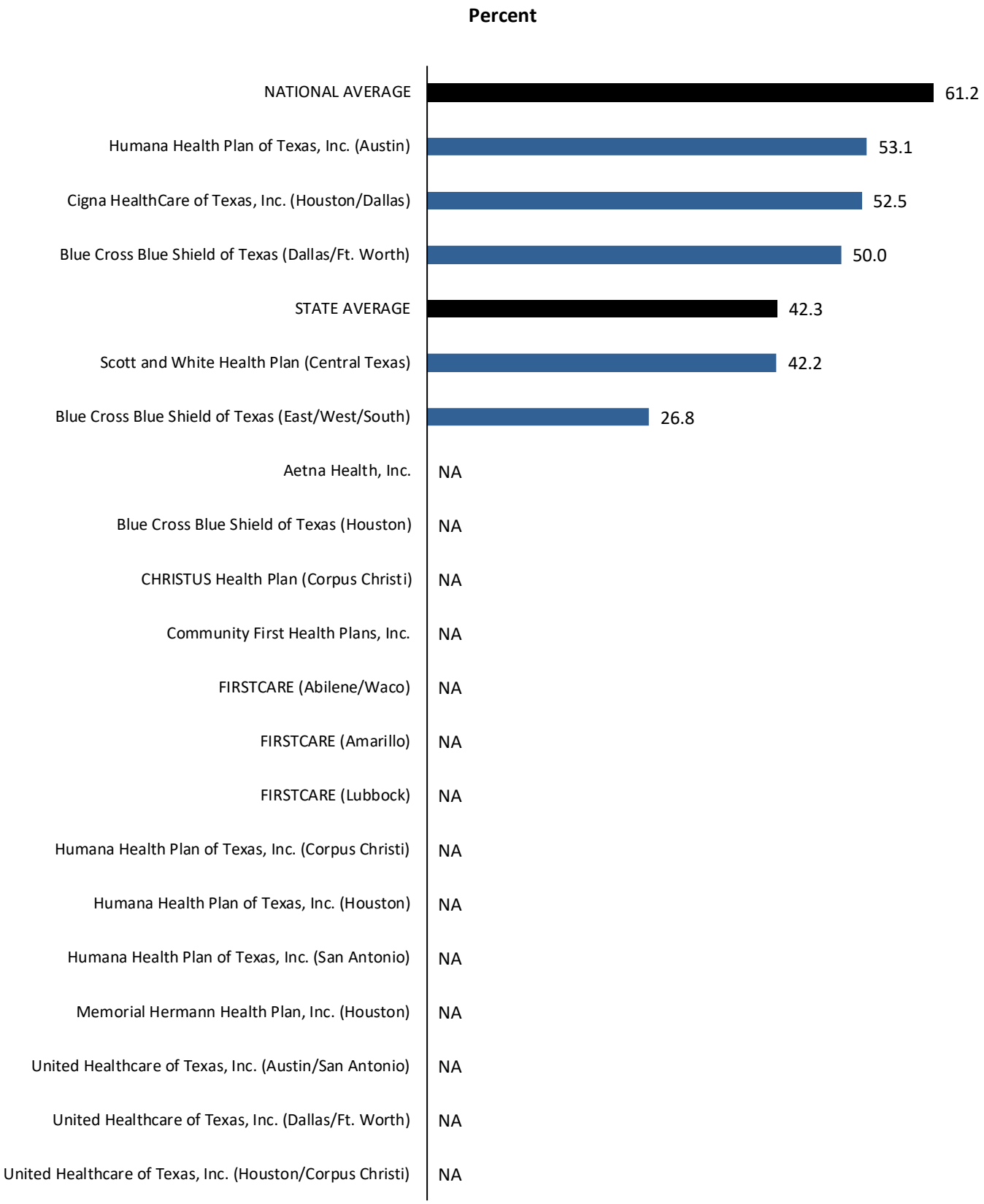
[1] Krevenbuhl, J., I. Nossel, L. Dixon. 2009. "Disengagement from Mental Health Treatment among Individuals with Schizophrenia and Strategies for Facilitating Connections to Care: A Review of the literature." *Schizophrenia Bulletin*. 35: 696-703.

Follow-Up After ED Visit for Mental Illness: 7 Days



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Follow-Up After ED Visit for Mental Illness: 30 Days



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Follow-Up After Emergency Department Visit for Alcohol or Other Drug Abuse or Dependence

DEFINITION:

This measure assesses the percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Alcohol or Other Drug (AOD) Abuse or Dependence can have serious, irreversible effects on health and well-being. Several studies have demonstrated that substance abuse treatment during or after an ED visit has been linked to a reduction in substance use, future ED use, hospital admissions, and bed days.[1 2 3]

This measure focuses on individuals with AOD abuse or dependence who return to the community after a visit to the ED, because they may be particularly vulnerable to losing contact with the health care system. High use of the ED may signal a lack of access to ongoing care or a gap in fulfilling urgent care needs. Linking patients to appropriate follow-up care may reduce future ED visits.[4]

This measure was added to the Texas Subset beginning with HEDIS® 2018.

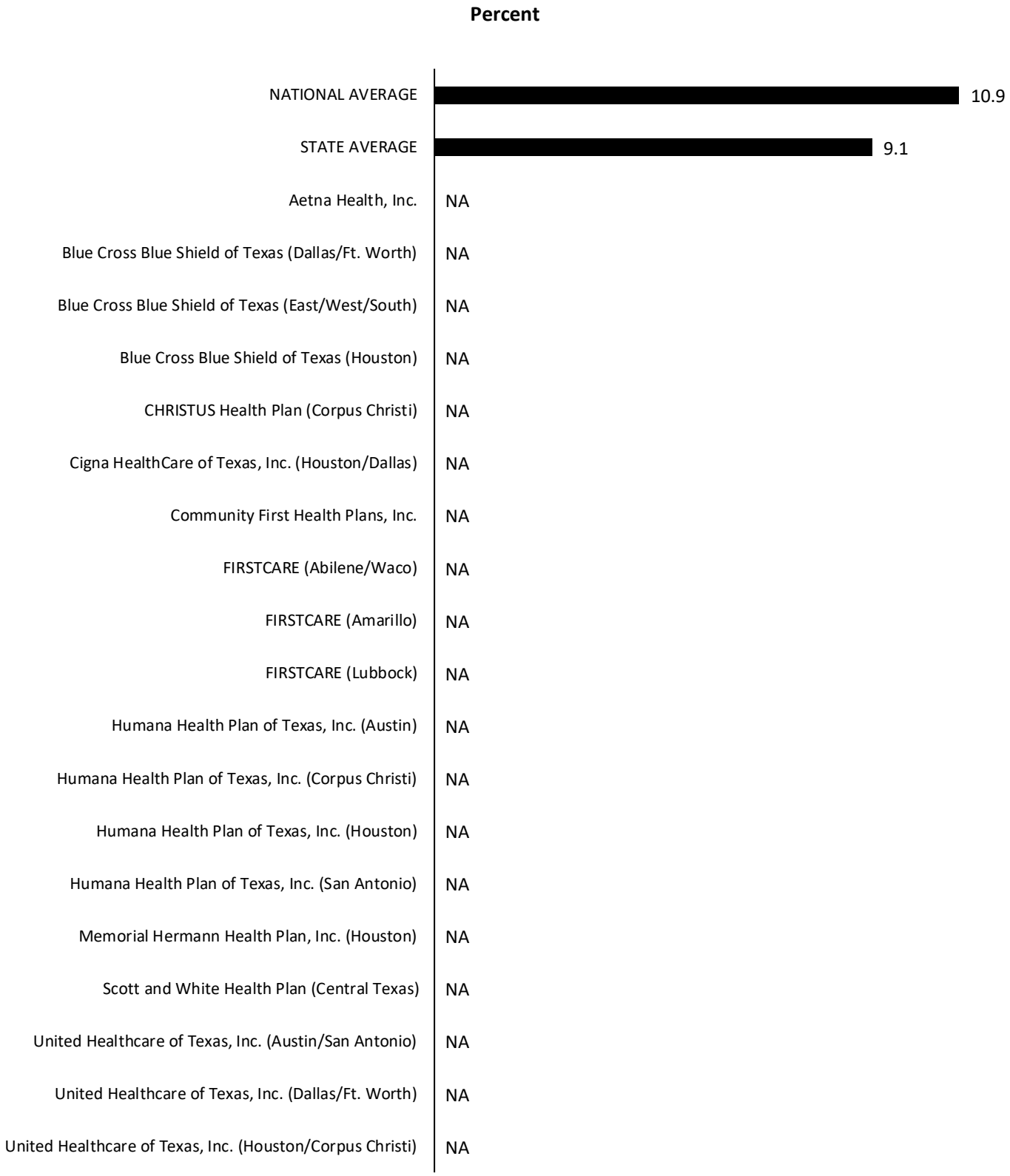
Follow-Up After ED Visit for AOD Abuse or Dependence: Total

	2016		2017		2018		2019		2020	
	TX	QC	TX	QC	TX	QC	TX	QC	TX	QC
7 Days (Total)	**	**	**	**	5.7%	10.9%	5.1%	11.3%	4.0%	11.3%
30 Days (Total)	**	**	**	**	6.8%	15.0%	6.0%	15.5%	6.6%	15.2%

Quality Compass® (QC) is a national database of health plan-specific performance information voluntarily reported to the NCQA.
**Value not established or not obtained.

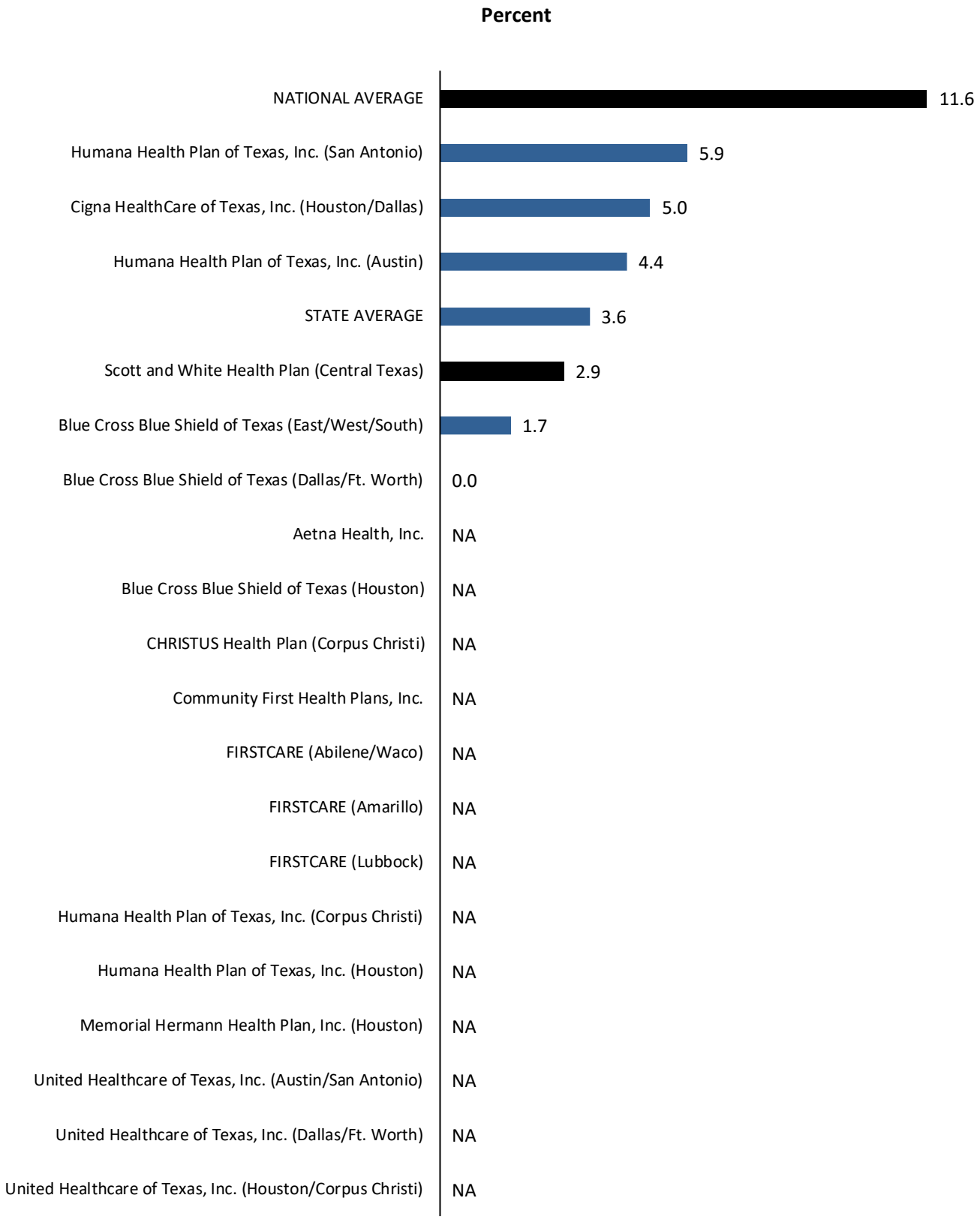
[1] Kunz, F.M., M.T. French, S. Bazargan-Hejazi. 2004. "Cost-effectiveness analysis of a brief intervention delivered to problem drinkers presenting at an inner-city hospital emergency department." *Journal of Studies on Alcohol and Drugs*. 65: 363-370.
[2] Mancuso, D., D.J. Nordlund, B. Felver. 2004. "Reducing emergency room visits through chemical dependency treatment: focus on frequent emergency room visitors." Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division. www1.dshs.wa.gov/pdf/ms/rda/research/11/121.pdf
[3] Parthasarathy S., C. Weisner, T. W. Hu, C. Moore. 2001. "Association of outpatient alcohol and drug treatment with health care utilization and cost: revisiting the offset hypothesis." *Journal of Studies on Alcohol and Drugs*. 62: 89-97.
[4] New England Health Care Institute (NEHI). 2010. "A Matter of Urgency: Reducing Emergency Department Overuse, A NEHI Research Brief." www.nehi.net/writable/publication_files/file/nehi_ed_overuse_issue_brief_032610finaledits.pdf

Follow-Up After ED Visit for AOD Abuse or Dependence: 7 Days (Age 13-17)



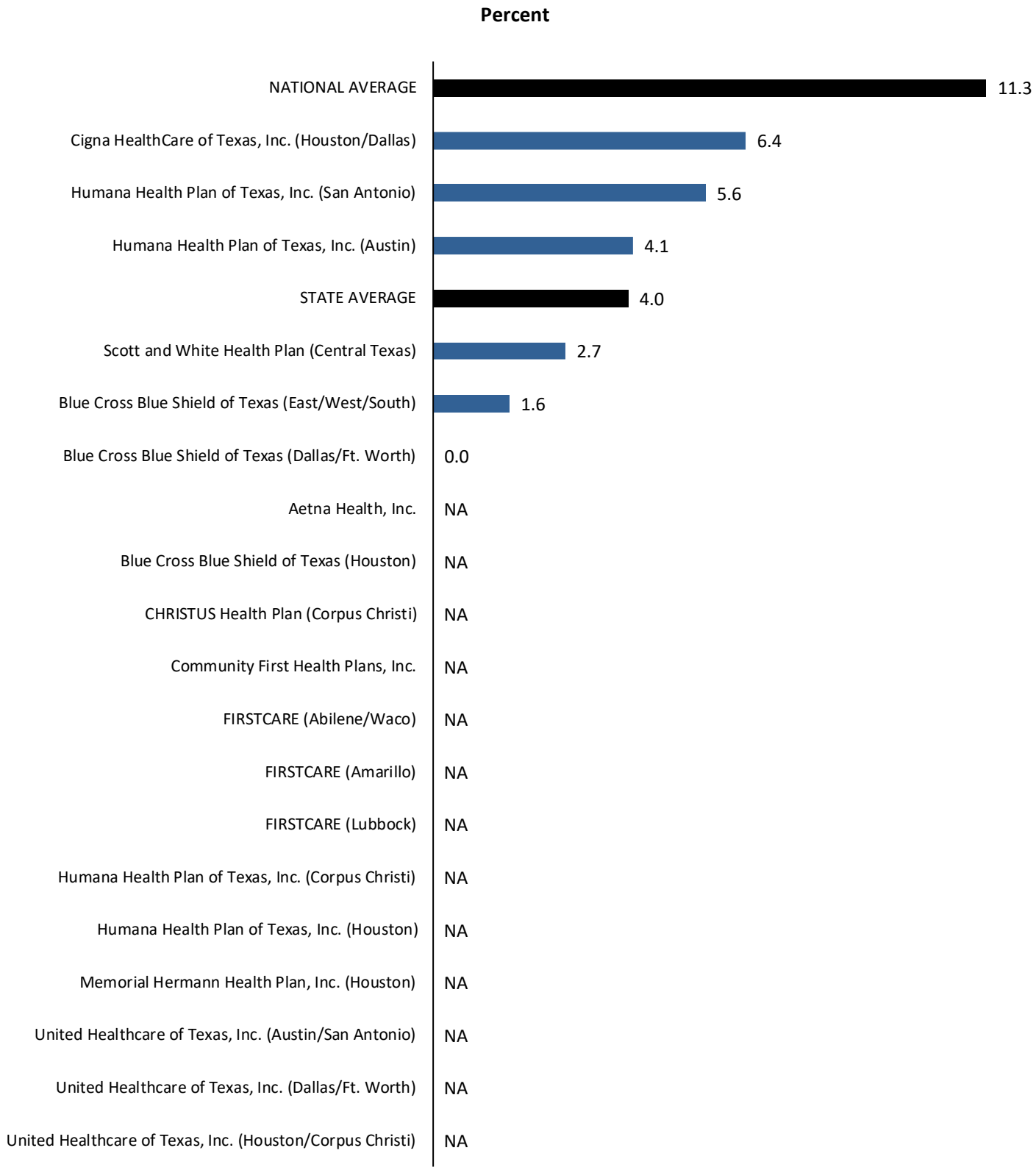
NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Follow-Up After ED Visit for AOD Abuse or Dependence: 7 Days (Age 18+)



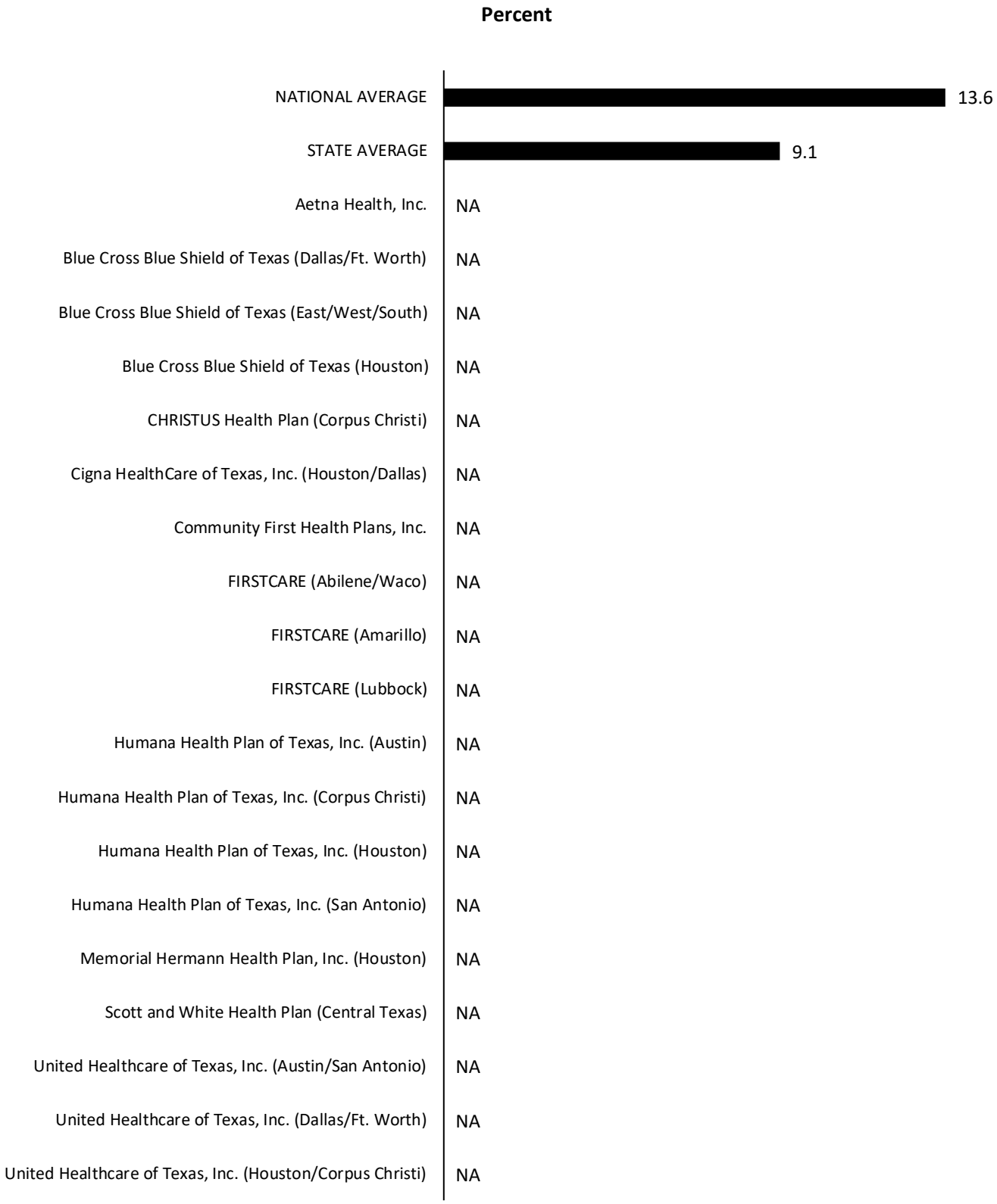
NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Follow-UP After ED Visit for AOD Abuse or Dependence: 7 Days (Total)



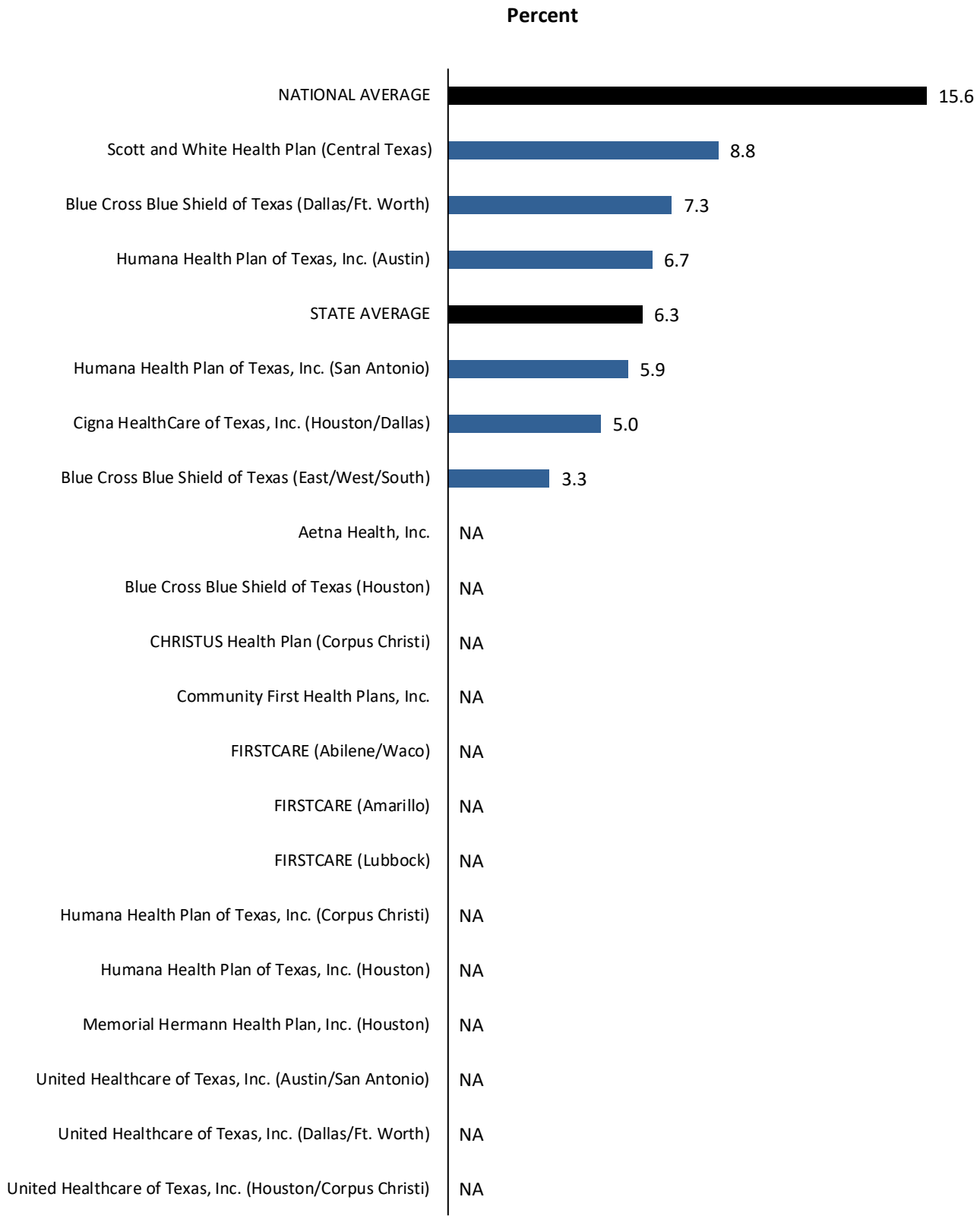
NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Follow-Up After ED Visit for AOD Abuse or Dependence: 30 Days (Age 13-17)



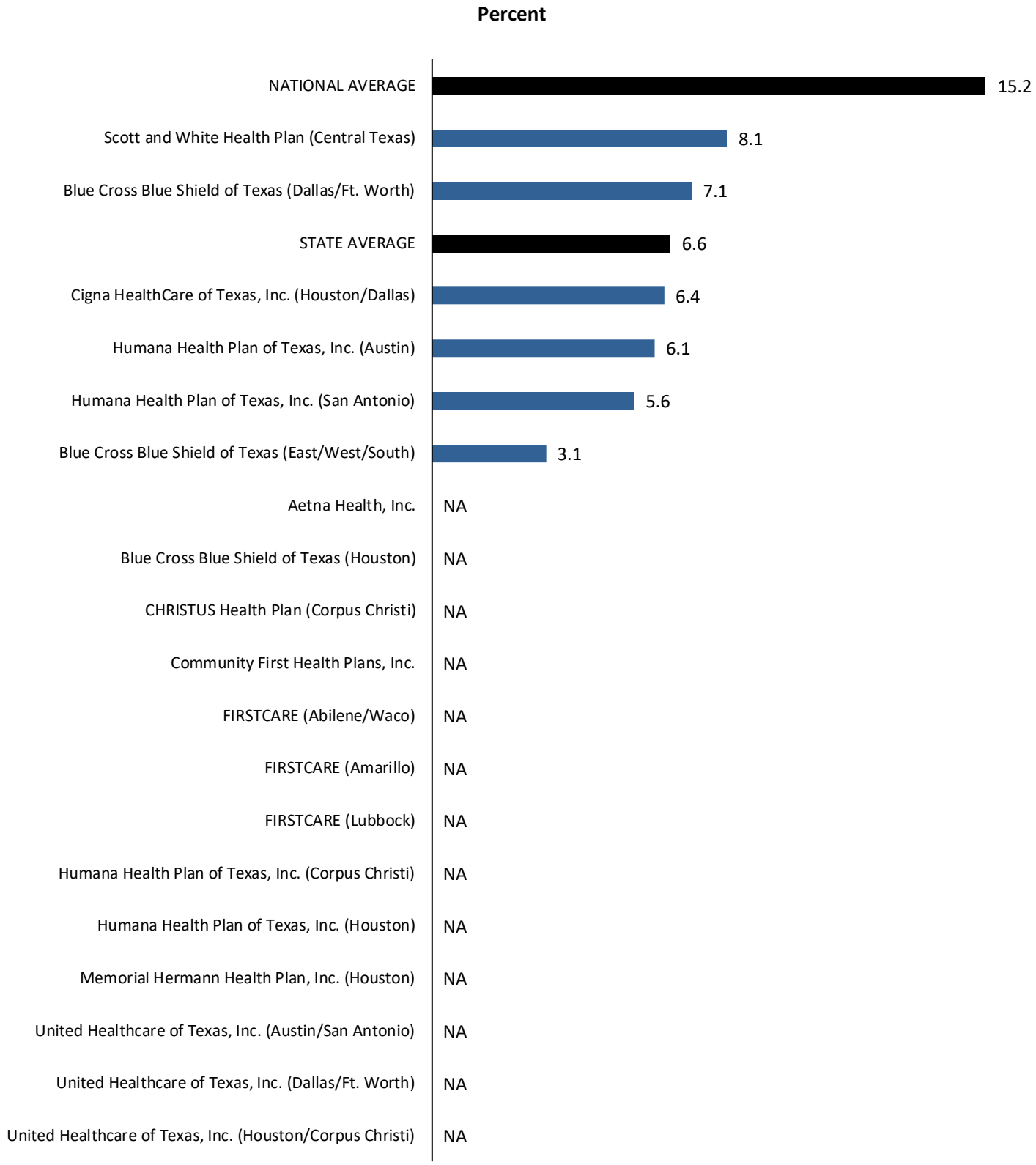
NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Follow-Up After ED Visit for AOD Abuse or Dependence: 30 Days (Age 18+)



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Follow-Up After ED Visit for AOD Abuse or Dependence: 30 Days (Total)



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Use of Opioids at High Dosage

DEFINITION:

This measure assesses the proportion of members 18 years and older who received prescription opioids at a high dosage (average milligram morphine dose [MME ≥90 mg) for ≥15 days during the measurement year.

The morbidity and mortality associated with opioid use has reached epidemic proportions and is recognized by the Centers for Disease Control and Prevention, the Surgeon General, and the White House as a significant public health problem in the U.S.

Although prescription opioids are appropriate components of a pain management treatment plan for certain conditions, there is limited evidence demonstrating the long-term beneficial effects of opioid use for chronic pain management for nonterminal conditions.[1] In addition, long-term daily use of opioids can lead to increased tolerance, addiction or dependence.[2] Studies suggest a correlation between high opioid dosage and a greater risk of overdoses and fractures.[3]

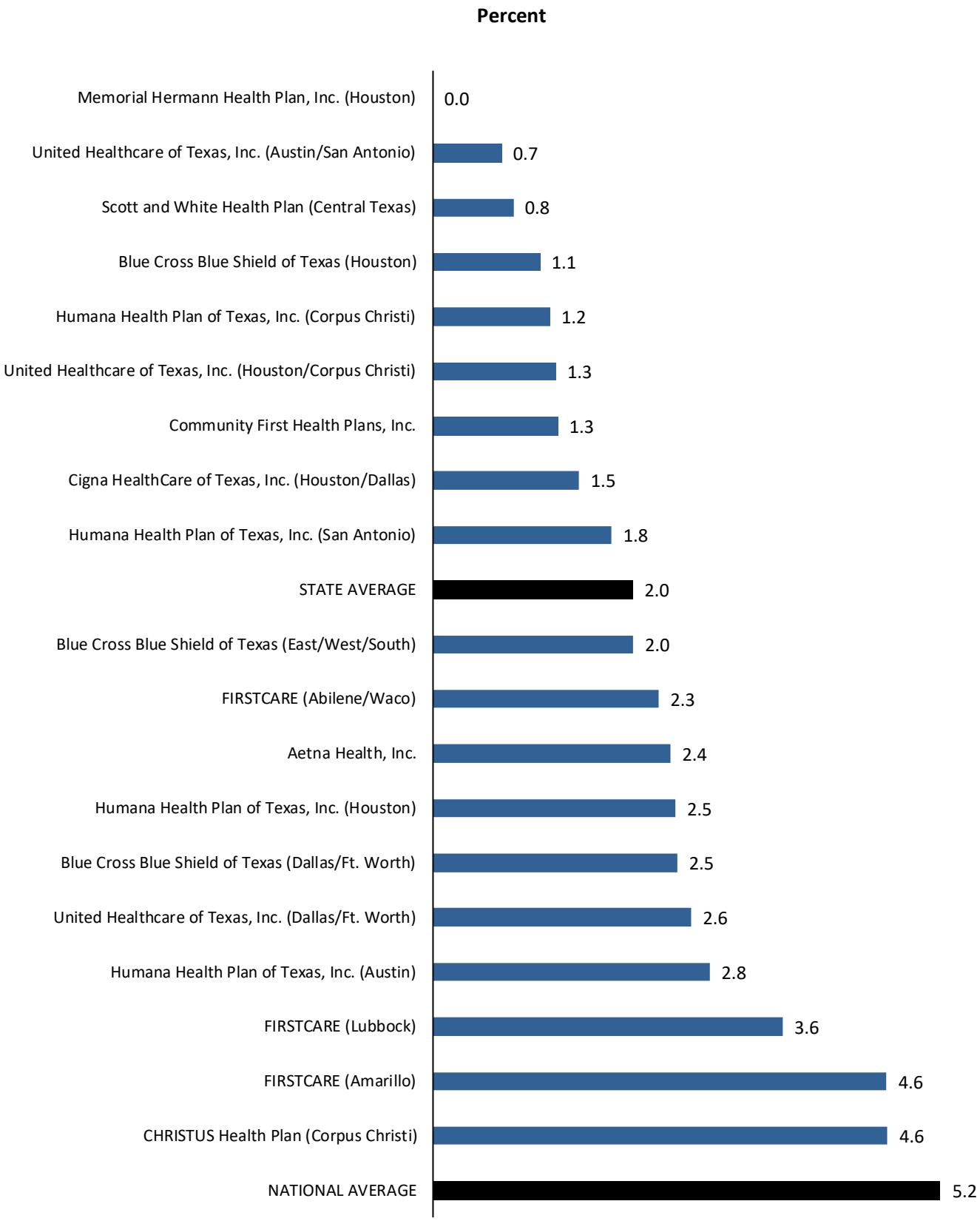
**Note: Lower rates indicate better performance for this measure.*
This measure was added to the Texas Subset beginning with HEDIS® 2020.

Use of Opioids at High Dosage					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	**	**	**	**	2.0%
NCQA's Quality Compass®	**	**	**	**	5.2%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.
**Value not established or not obtained.

[1] Chou R., G.J. Fanciullo, P.G. Fine, et al. 2009. "Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain." *Journal of Pain* 10(2):113–30.
[2] National Institutes of Health (NIH). 2011. "Opioids and Chronic Pain." *Medline Plus.* https://www.nlm.nih.gov/medlineplus/magazine/issues/spring11/articles/spring11pg9.html
[3] Dunn, K.M., K.W. Saunders, C.M. Rutter, C.J. Banta-Green, J.O. Merrill, M.D. Sullivan, M. Von Korff. 2010. "Overdose and prescribed opioids: Associations among chronic non-cancer pain patients." *Annals of Internal Medicine* 152(2), 85–92. http://doi.org/10.1059/0003-4819-152-2-201001190-00006

Use of Opioids at High Dosage



**Note: Lower rates indicate better performance for this measure.*

Use of Opioids from Multiple Providers: Multiple Pharmacies

DEFINITION:

The rate per 1,000 members receiving prescriptions for opioids from 4 or more pharmacies.

The morbidity and mortality associated with opioid use has reached epidemic proportions and is recognized by the Centers for Disease Control and Prevention, the Surgeon General, and the White House as a significant public health problem in the U.S. One area of risk related to opioid use is the receipt of opioids prescriptions from multiple prescribers and pharmacies. Prescription drug monitoring programs (PDMP), which are state-run electronic databases that collect statewide data on the prescribing and dispensing of controlled prescription drugs to patients, have found that the highest use of opioids is found among a small proportion of patients who use multiple providers and pharmacies.

Evidence suggests that people who see multiple prescribers and use multiple pharmacies are at higher risk of overdose.[1] Studies also show that patients who use 4 or more prescribers or pharmacies have a higher likelihood of opioid-related overdose death compared to patients who receive opioids from 1 prescriber or 1 physician.[2]

**Note: Lower rates indicate better performance for this measure.*
This measure was added to the Texas Subset beginning with HEDIS® 2020.

Use of Opioids from Multiple Providers: Multiple Pharmacies					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	**	**	**	**	7.4%
NCQA's Quality Compass®	**	**	**	**	3.6%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.
**Value not established or not obtained.

[1] Dunn, K.M., K.W. Saunders, C.M. Rutter, C.J. Banta-Green, J.O. Merrill, M.D. Sullivan, M. Von Korff. 2010. "Overdose and prescribed opioids: Associations among chronic non-cancer pain patients." *Annals of Internal Medicine* 152(2), 85–92. http://doi.org/10.1059/0003-4819-152-2-201001190-00006

[2] Gwira Baumblatt, J.A., C. Wiedeman, J.R. Dunn, W. Schaffner, L.J. Paulozzi, T.F. Jones. 2014. *High-risk use by patients prescribed opioids for pain and its role in overdose deaths*. JAMA Intern Med 174(5):796–801. PMID: 24589873

Use of Opioids From Multiple Providers: Multiple Pharmacies

**Note: Lower rates indicate better performance for this measure.*

Use of Opioids from Multiple Providers: Multiple Prescribers

DEFINITION:

The rate per 1,000 members receiving prescriptions for opioids from 4 or more prescribers.

The morbidity and mortality associated with opioid use has reached epidemic proportions and is recognized by the Centers for Disease Control and Prevention, the Surgeon General, and the White House as a significant public health problem in the U.S. One area of risk related to opioid use is the receipt of opioids prescriptions from multiple prescribers and pharmacies. Prescription drug monitoring programs (PDMP), which are state-run electronic databases that collect statewide data on the prescribing and dispensing of controlled prescription drugs to patients, have found that the highest use of opioids is found among a small proportion of patients who use multiple providers and pharmacies.

Evidence suggests that people who see multiple prescribers and use multiple pharmacies are at higher risk of overdose.[1] Studies also show that patients who use 4 or more prescribers or pharmacies have a higher likelihood of opioid-related overdose death compared to patients who receive opioids from 1 prescriber or 1 physician.[2]

**Note: Lower rates indicate better performance for this measure.*
This measure was added to the Texas Subset beginning with HEDIS® 2020.

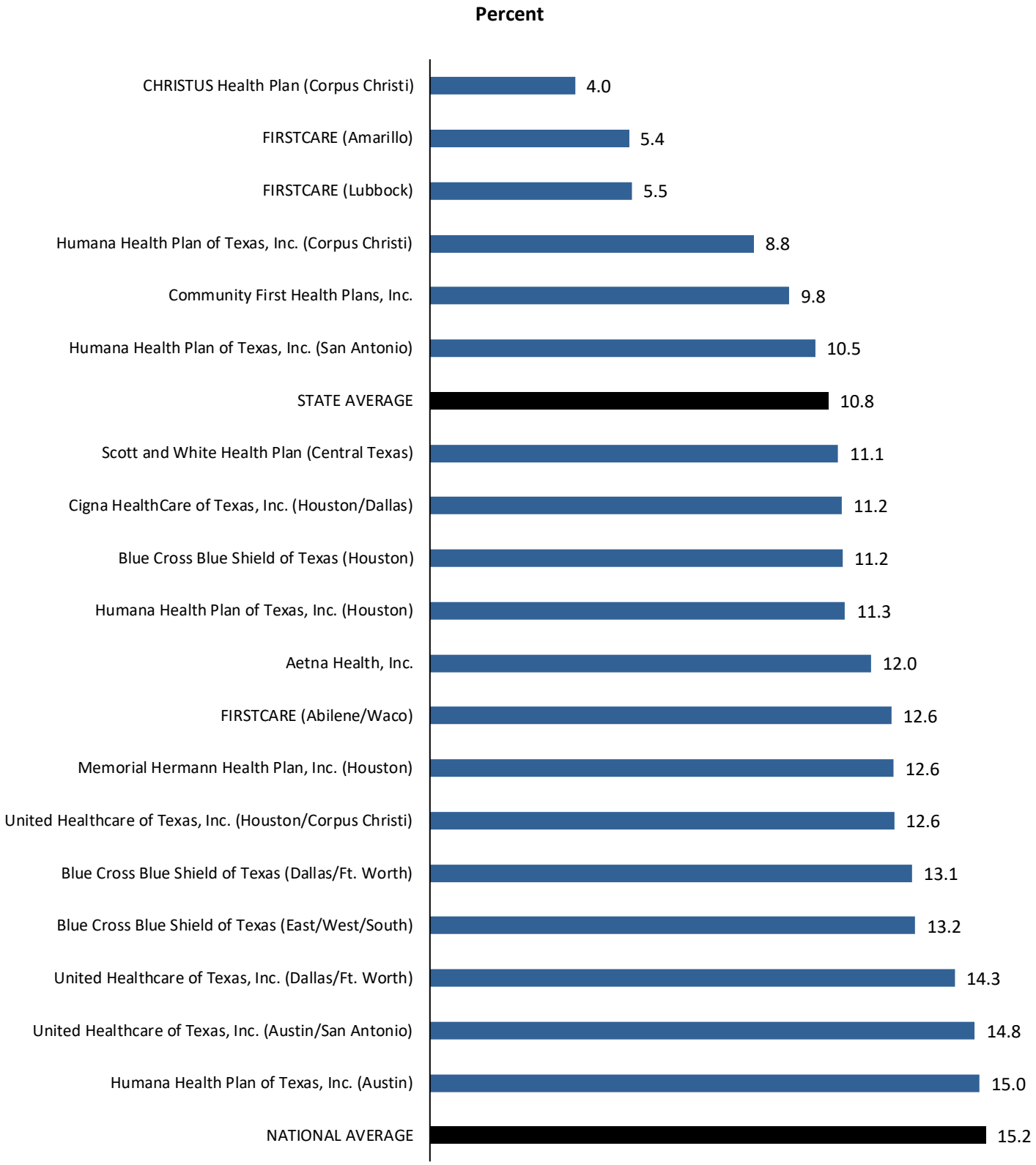
Use of Opioids from Multiple Providers: Multiple Prescribers					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	**	**	**	**	10.8%
NCQA's Quality Compass®	**	**	**	**	15.2%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.
**Value not established or not obtained.

[1] Dunn, K.M., K.W. Saunders, C.M. Rutter, C.J. Banta-Green, J.O. Merrill, M.D. Sullivan, M. Von Korff. 2010. "Overdose and prescribed opioids: Associations among chronic non-cancer pain patients." *Annals of Internal Medicine* 152(2), 85–92. http://doi.org/10.1059/0003-4819-152-2-201001190-00006

[2] Gwira Baumblatt, J.A., C. Wiedeman, J.R. Dunn, W. Schaffner, L.J. Paulozzi, T.F. Jones. 2014. *High-risk use by patients prescribed opioids for pain and its role in overdose deaths*. JAMA Intern Med 174(5):796–801. PMID: 24589873

Use of Opioids From Multiple Providers: Multiple Prescribers



**Note: Lower rates indicate better performance for this measure.*

Use of Opioids from Multiple Providers: Multiple Prescribers and Multiple Pharmacies

DEFINITION:

The rate per 1,000 members receiving prescriptions for opioids from 4 or more prescribers and 4 or more pharmacies. (i.e., the rate per 1,000 of members who are numerator compliant for both the Multiple Prescribers and Multiple Pharmacies rates).

The morbidity and mortality associated with opioid use has reached epidemic proportions and is recognized by the Centers for Disease Control and Prevention, the Surgeon General, and the White House as a significant public health problem in the U.S. One area of risk related to opioid use is the receipt of opioids prescriptions from multiple prescribers and pharmacies. Prescription drug monitoring programs (PDMP), which are state-run electronic databases that collect statewide data on the prescribing and dispensing of controlled prescription drugs to patients, have found that the highest use of opioids is found among a small proportion of patients who use multiple providers and pharmacies.

Evidence suggests that people who see multiple prescribers and use multiple pharmacies are at higher risk of overdose.[1] Studies also show that patients who use 4 or more prescribers or pharmacies have a higher likelihood of opioid-related overdose death compared to patients who receive opioids from 1 prescriber or 1 physician.[2]

**Note: Lower rates indicate better performance for this measure.*
This measure was added to the Texas Subset beginning with HEDIS® 2020.

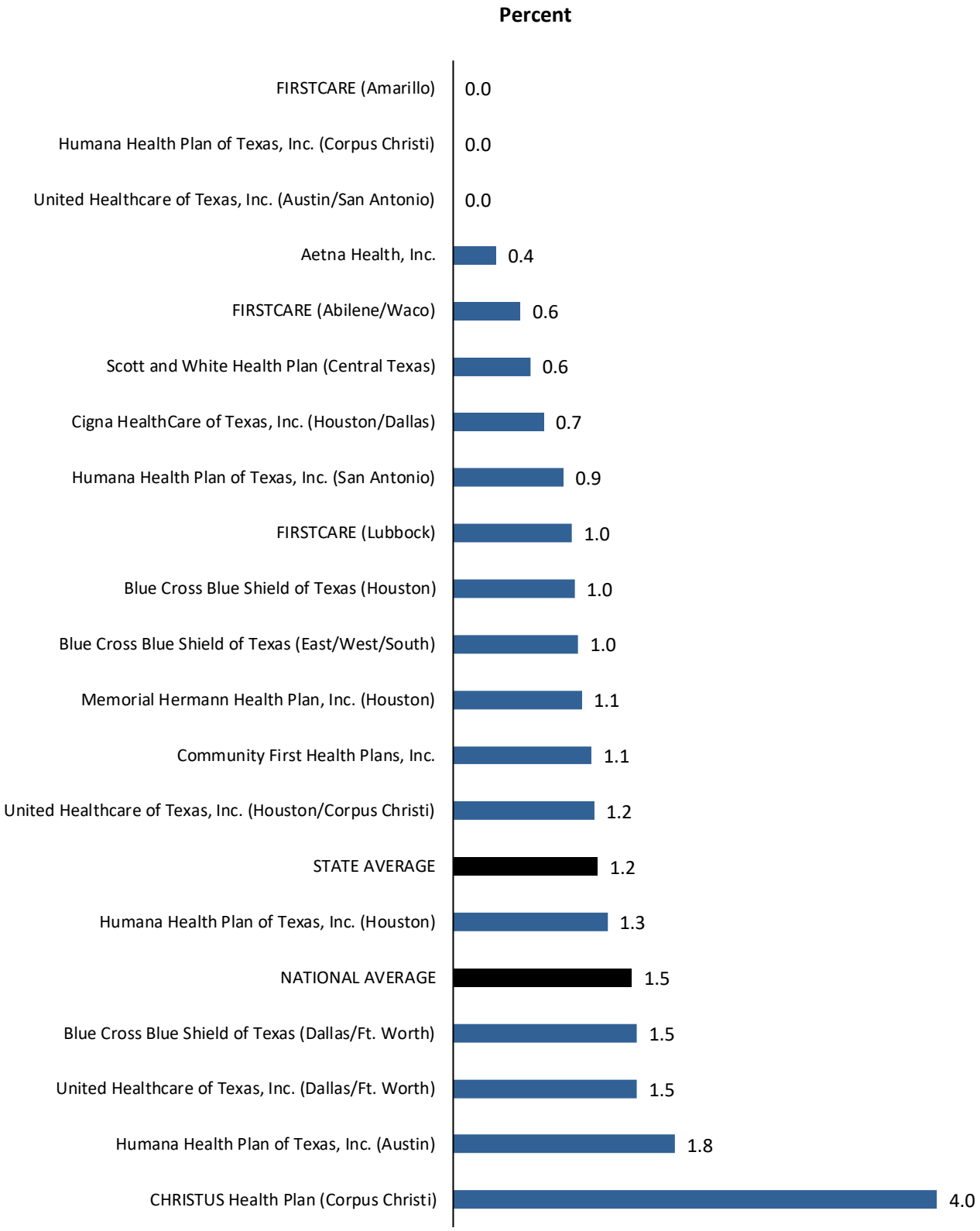
Use of Opioids from Multiple Prescribers: Multiple Prescribers and Multiple Pharmacies					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	**	**	**	**	1.2%
NCQA's Quality Compass®	**	**	**	**	1.5%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.
**Value not established or not obtained.

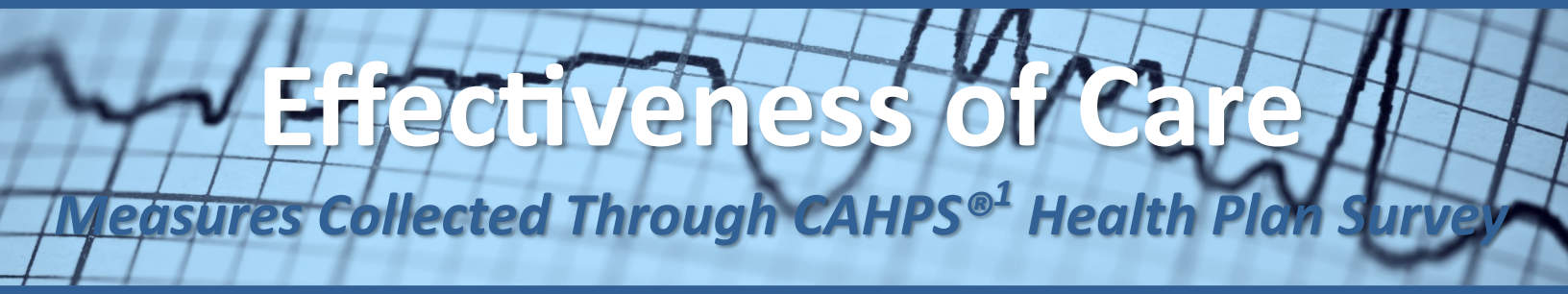
[1] Dunn, K.M., K.W. Saunders, C.M. Rutter, C.J. Banta-Green, J.O. Merrill, M.D. Sullivan, M. Von Korff. 2010. "Overdose and prescribed opioids: Associations among chronic non-cancer pain patients." *Annals of Internal Medicine* 152(2), 85–92. http://doi.org/10.1059/0003-4819-152-2-201001190-00006

[2] Gwira Baumblatt, J.A., C. Wiedeman, J.R. Dunn, W. Schaffner, L.J. Paulozzi, T.F. Jones. 2014. *High-risk use by patients prescribed opioids for pain and its role in overdose deaths*. JAMA Intern Med 174(5):796–801. PMID: 24589873

Use of Opioids From Multiple Providers: Multiple Prescribers and Multiple Pharmacies



**Note: Lower rates indicate better performance for this measure.*



Effectiveness of Care

Measures Collected Through CAHPS®[1] Health Plan Survey

Flu Vaccinations for Adults Age 18-64

DEFINITION:

The percentage of members 18-64 years of age who received an influenza (flu) vaccination.

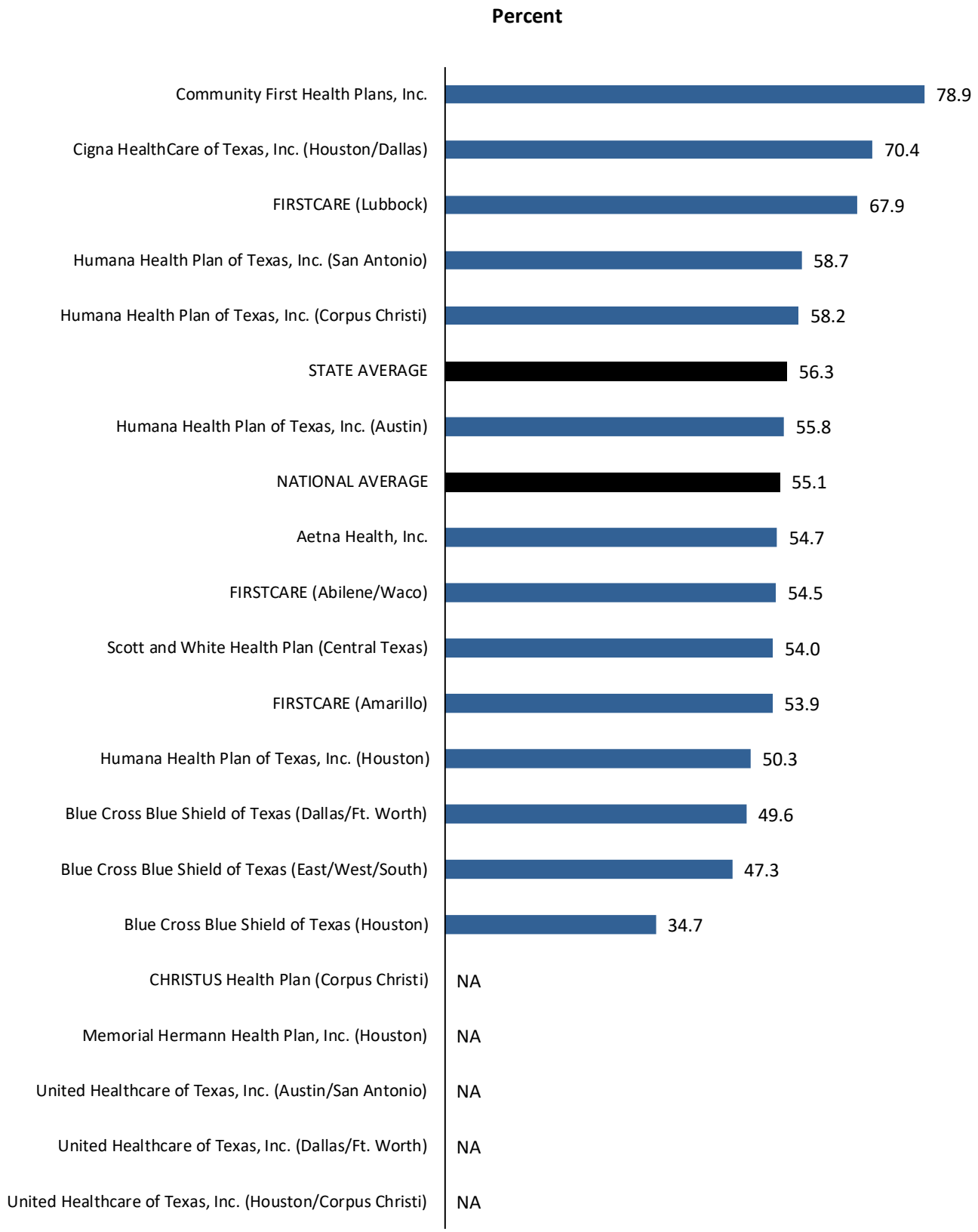
The **flu** is a highly contagious viral illness. Symptoms can include fever, sore throat, headache, cough, and sore muscles. Complications can include pneumonia (a lung infection) and myocarditis (inflammation of the heart).[1] Children under 5 and adults over 50 have a higher risk of complications and death from the disease. The Advisory Committee on Immunization Practices (ACIP) recommends yearly influenza vaccinations for all individuals over the 6 months.[2]

Flu Vaccinations for Adults Age 18-64					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	47.1%	45.1%	50.9%	53.3%	56.3%
NCQA's Quality Compass®	48.4%	**	50.5%	52.7%	55.1%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.
**Value not established or not obtained.

[1] Hamborsky, Jennifer, Andrew Kroger, and Charles Wolfe, eds. Centers for Disease Control and Prevention. *Epidemiology and Prevention of Vaccine-Preventable Diseases*. 13th ed. Washington, D.C.: Public Health Foundation, 2015.
[2] Centers for Disease Control and Prevention. *Recommended Adult Immunization Schedule, by Vaccine and Age Group*. Atlanta, GA: Centers for Disease Control and Prevention, 2016.

Flu Vaccinations for Adults Age 18-64



NA Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Medical Assistance with Smoking and Tobacco Use Cessation

DEFINITION:

This three-part survey measure examines the percentage of members 18 years of age and older who were current smokers or tobacco users or recent quitters, were seen by a medical practitioner, and 1) received advice from the practitioner to quit; 2) discussed cessation medications with the practitioner; or 3) discussed cessation strategies with the practitioner.

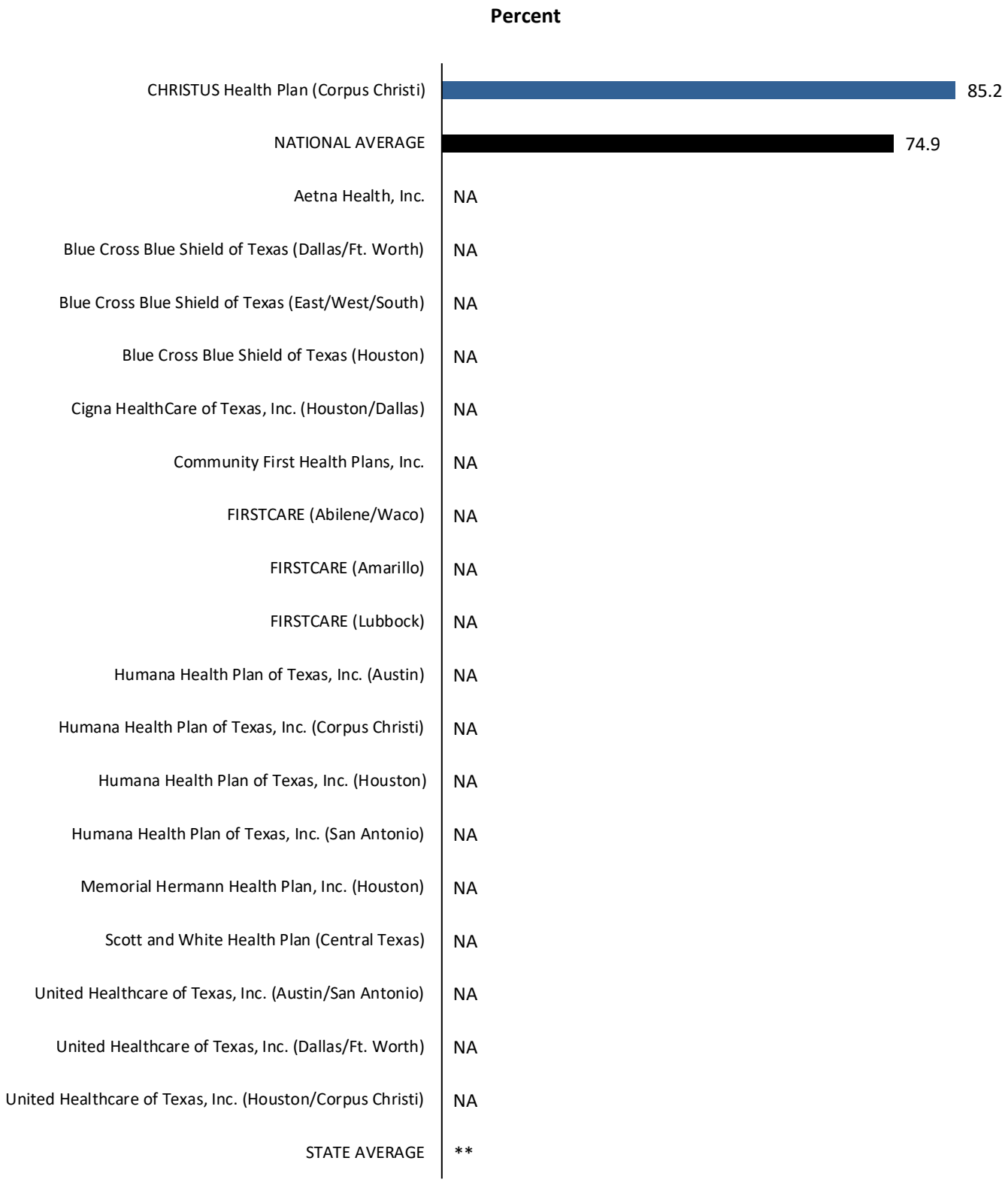
Smoking cessation reduces the risk of lung and other cancers, heart attack, stroke, and chronic lung disease. This three part survey measure examines the health care provider's role in curbing tobacco use and focuses on health care providers' efforts to help members quit smoking or tobacco use by evaluating the following components:

1. **Advising Smokers and Tobacco Users to Quit.** The percentage of members 18 years of age and older who are current smokers or tobacco users and received cessation advice from their practitioner.
2. **Discussing Cessation Medications.** The percentage of members 18 years of age and older who are current smokers or tobacco users who discussed or were recommended cessation medications.
3. **Discussing Cessation Strategies.** The percentage of members 18 years of age and older who are current smokers or tobacco users who discussed or were provided cessation methods or strategies.

Medical Assistance with Smoking and Tobacco Use Cessation										
	2016		2017		2018		2019		2020	
	TX	QC	TX	QC	TX	QC	TX	QC	TX	QC
Advising to Quit	**	75.9%	**	**	**	75.9%	**	77.8%	**	74.9%
Discussing Cessation Medications	**	50.3%	**	**	**	52.5%	**	55.5%	**	50.7%
Discussing Cessation Strategies	**	45.8%	**	**	**	45.7%	**	48.9%	**	48.0%

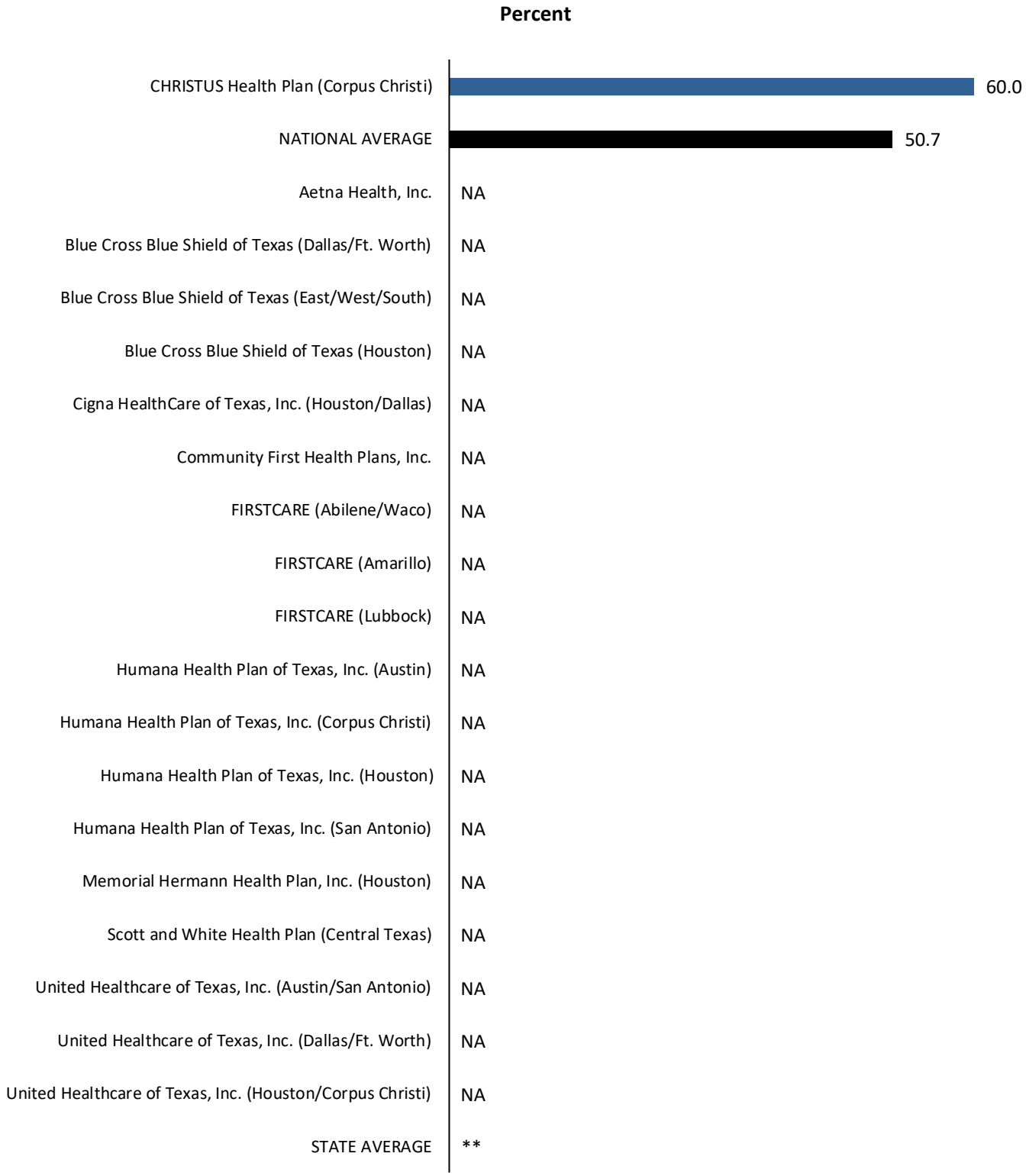
Quality Compass® (QC) is a national database of health plan-specific performance information voluntarily reported to the NCQA.
**Value not established or not obtained.

Medical Assistance With Smoking and Tobacco Use Cessation: Advising to Quit



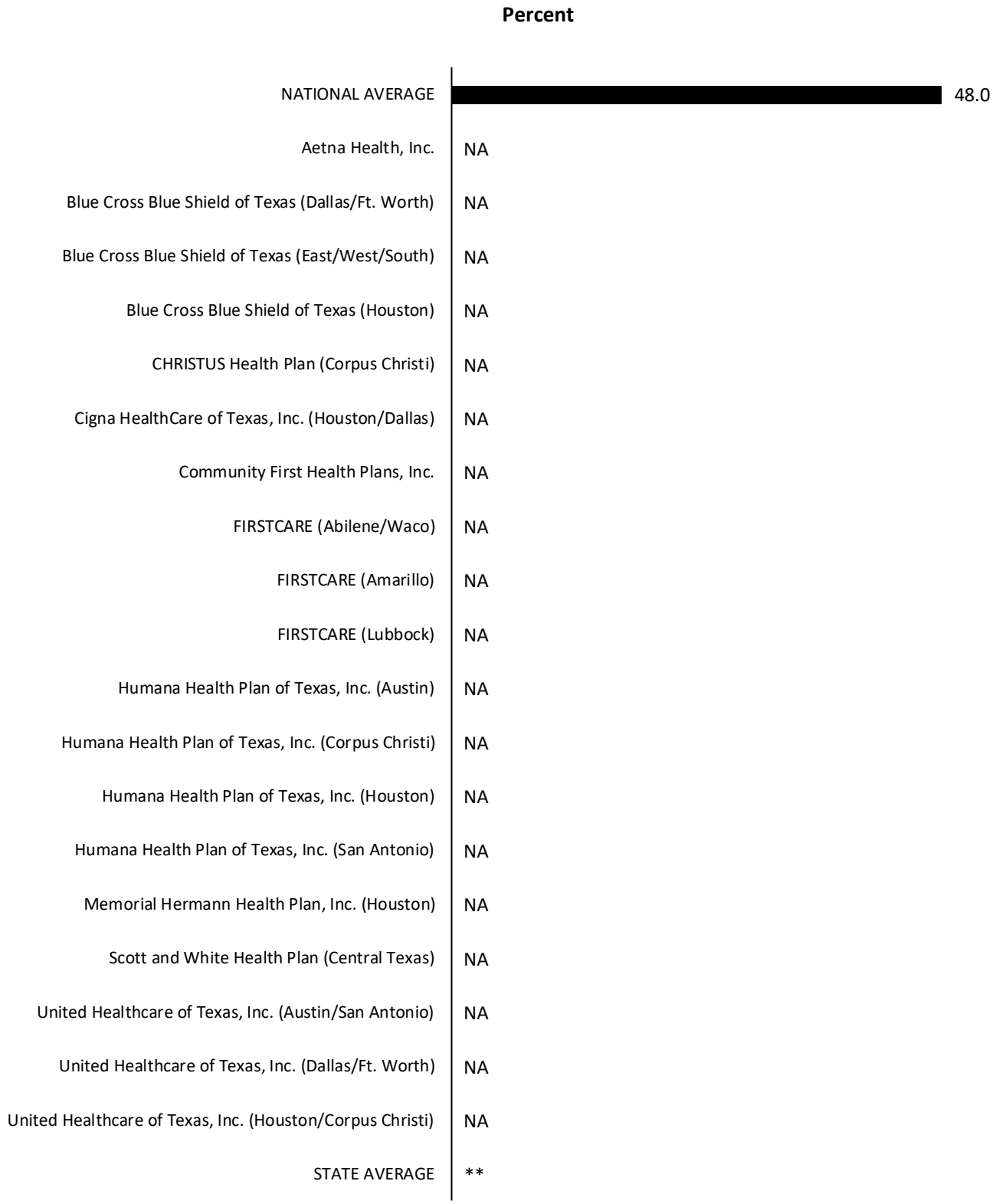
NA Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.
*** Value not established or not obtained.*

Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications



NA Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.
*** Value not established or not obtained.*

Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies



NA Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.
*** Value not established or not obtained.*

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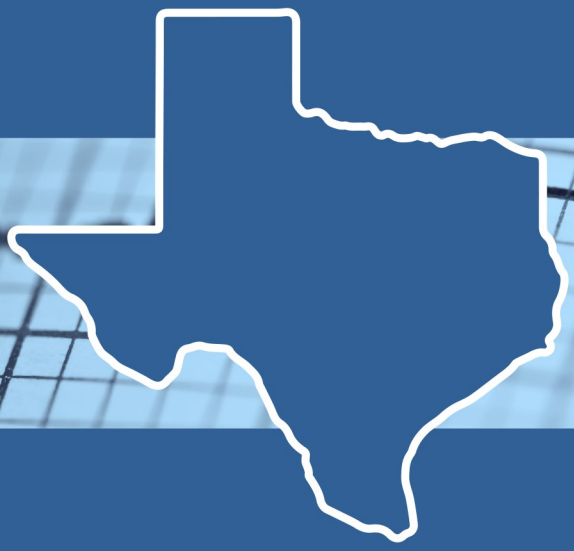


Section III

Access/Availability of Care

Adult Access to Preventative/Ambulatory Health Services

DEFINITION:

The percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year or the 2 years prior to the measurement year.

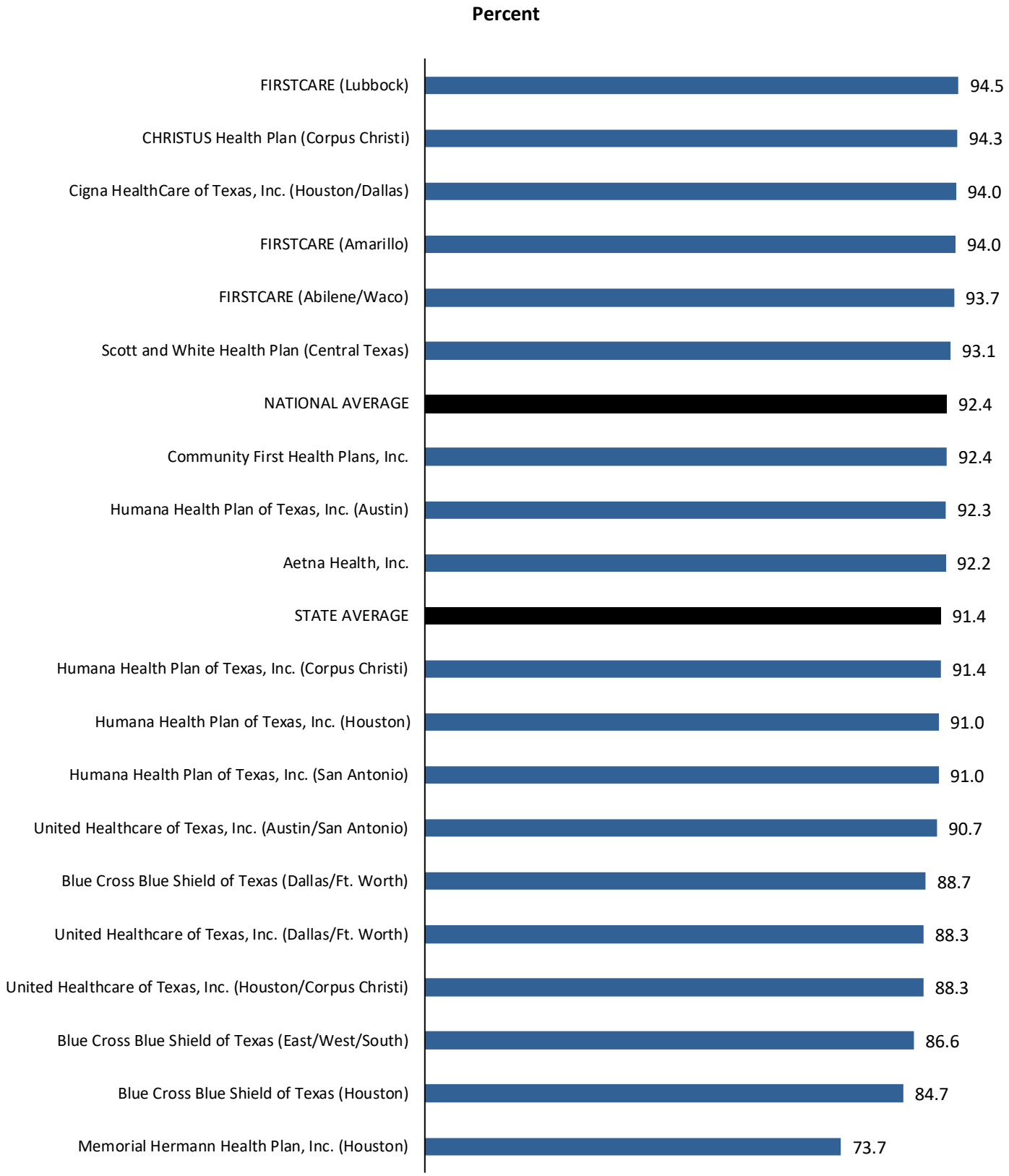
Health care visits are an opportunity for individuals to receive preventive services and counseling on topics such as diet and exercise. These visits also can help them to address acute issues or manage chronic conditions.

This measure looks at members' ability to obtain basic services they require from their HMO. Specifically, this measure indicates the percentage of members who have had a preventive or ambulatory visit to their physician. This measure indicates not only the percentage of members who do access care, but can also indicate barriers to care in the HMO.

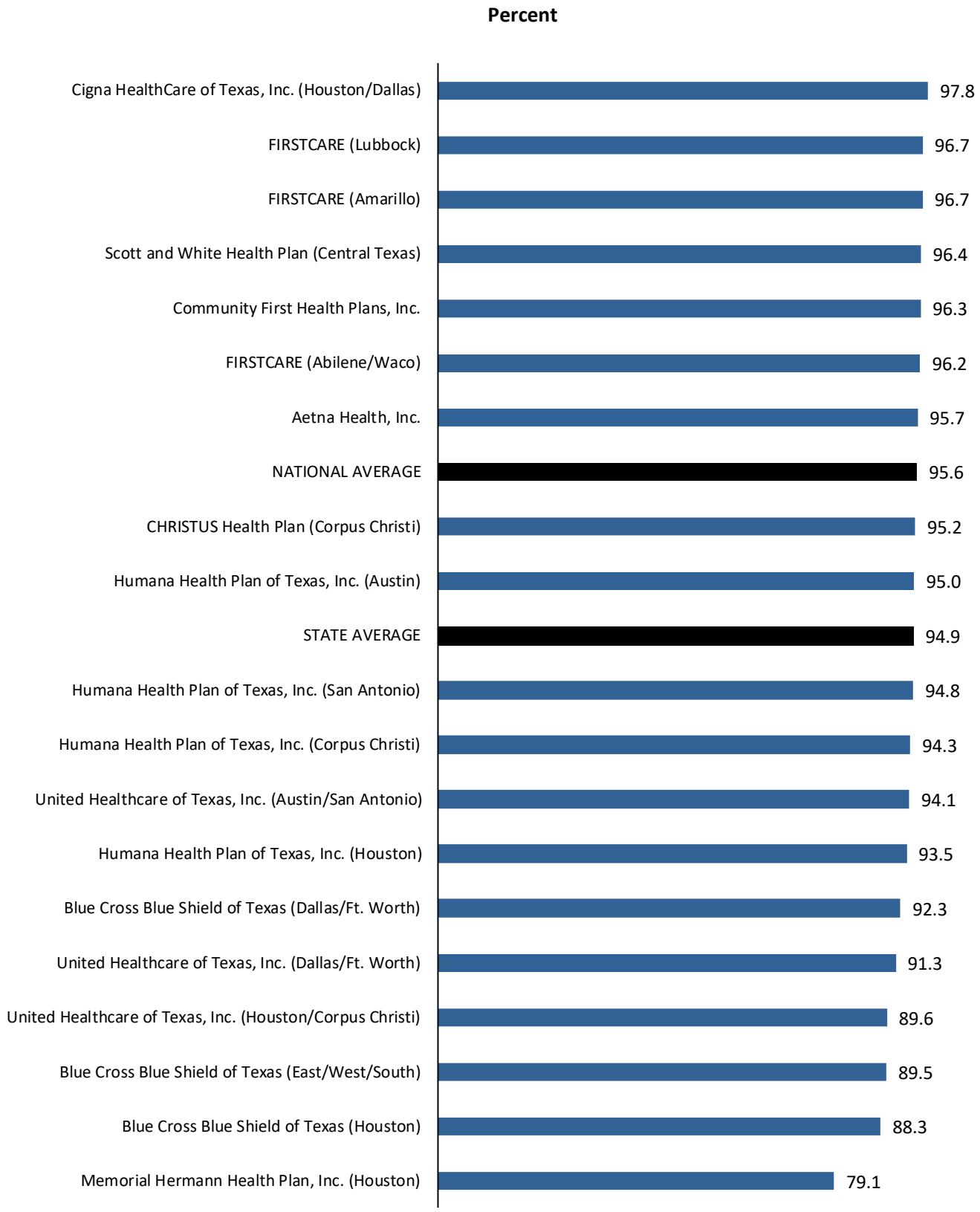
Adult Access to Preventative/Ambulatory Services: Total					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	94.4%	93.8%	92.7%	93.7%	93.6%
NCQA's Quality Compass®	94.6%	94.4%	94.1%	94.3%	94.3%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

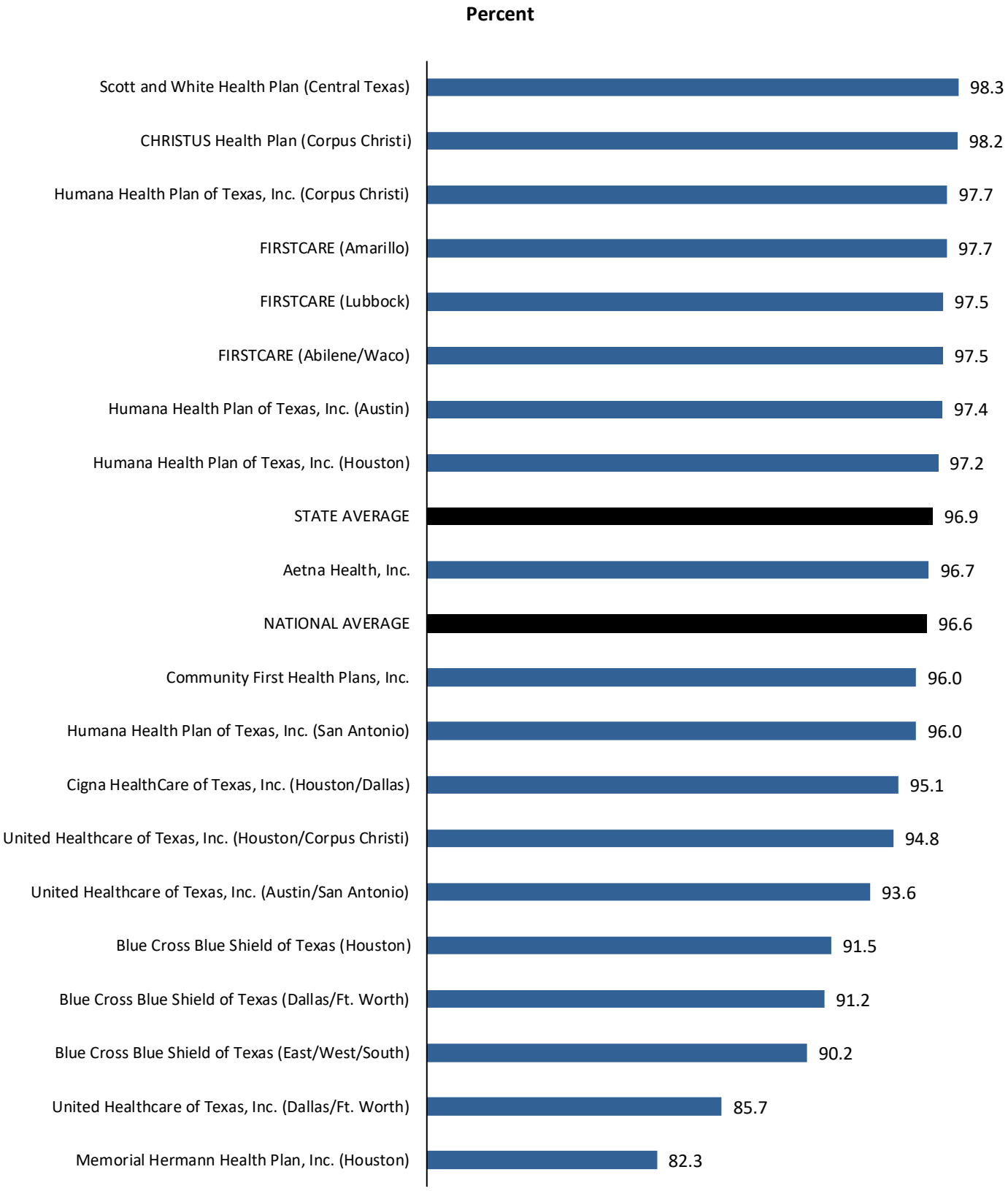
Adult Access to Preventative/Ambulatory Health Services: Age 20-44



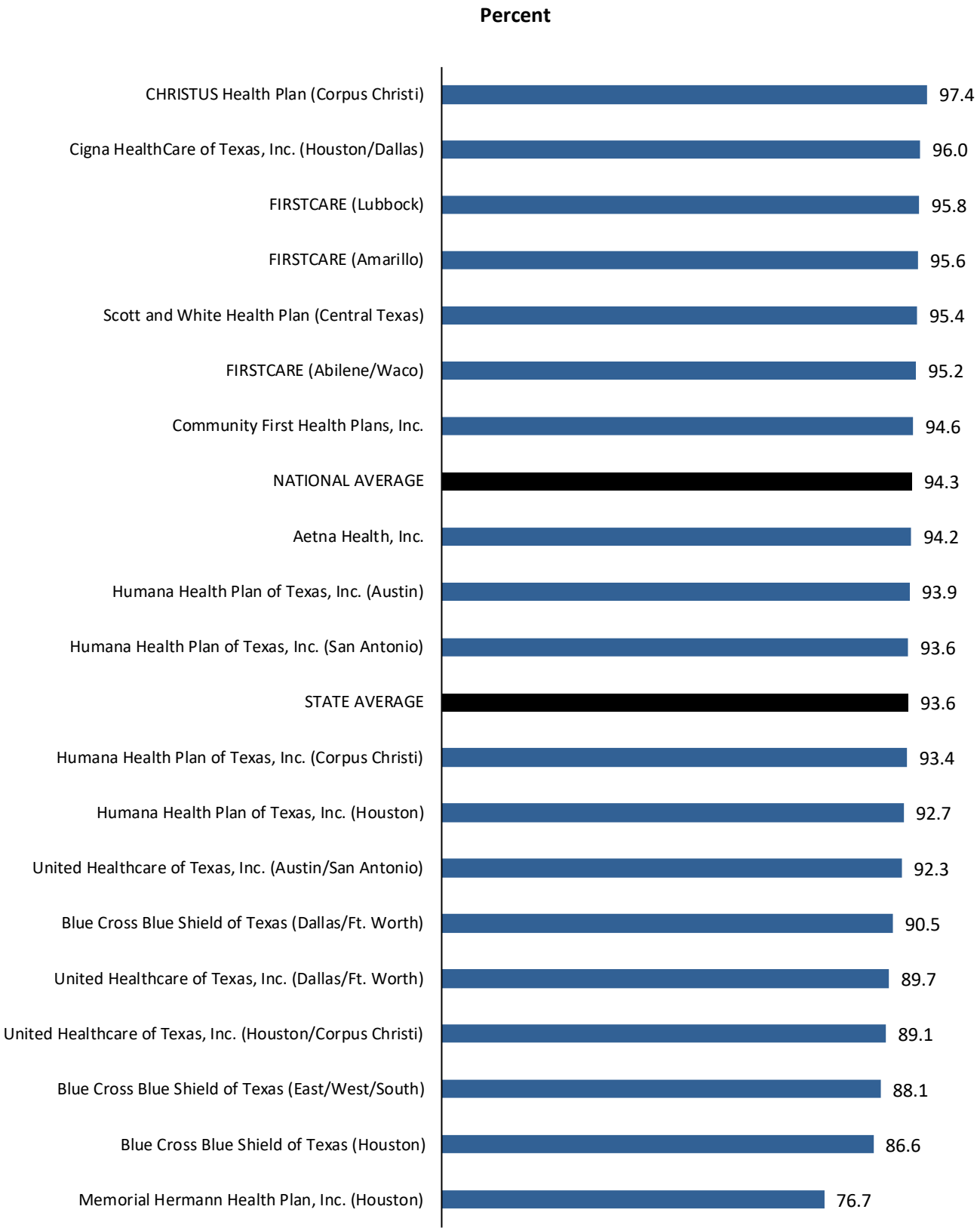
Adult Access to Preventative/Ambulatory Health Services: Age 45-64



Adult Access to Preventative/Ambulatory Health Services: Age 65+



Adult Access to Preventative/Ambulatory Health Services: Total



Prenatal and Postpartum Care: Timeliness of Prenatal Care

DEFINITION:

The percentage of deliveries where the mother received a prenatal care visit as a member of the HMO in the first trimester or within 42 days of enrollment in the HMO.

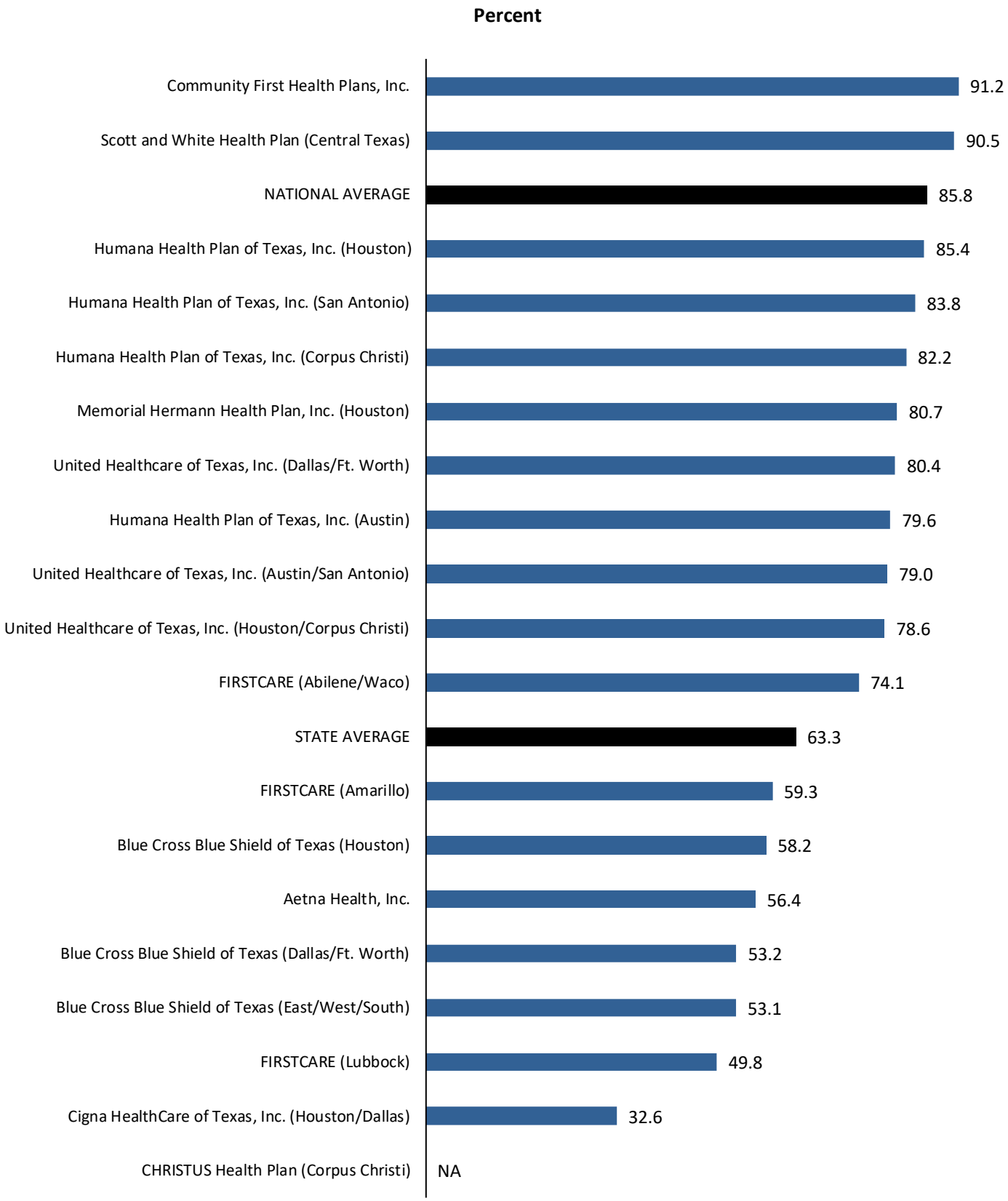
Early prenatal care is an essential part of a healthy pregnancy. Doctors can identify and treat health problems early when they see pregnant women regularly. Doctors can also advise pregnant women about healthy choices during pregnancy to provide their babies a healthy start to life. Ideally, a pregnant woman will have her first prenatal visit during the first trimester of pregnancy.[1]

Timeliness of Prenatal Care					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	73.7%	70.7%	69.6%	72.0%	63.3%
NCQA's Quality Compass®	83.7%	85.1%	84.2%	85.7%	85.8%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

[1] U.S. Department of Health and Human Services, Office on Women's Health. *Prenatal Care Fact Sheet*. Washington, D.C.: U.S. Department of Health and Human Services, 2012.

Timeliness of Prenatal Care



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Prenatal and Postpartum Care: Postpartum Care

DEFINITION:

The percentage of deliveries where the mother had a postpartum visit 21-56 days after delivery.

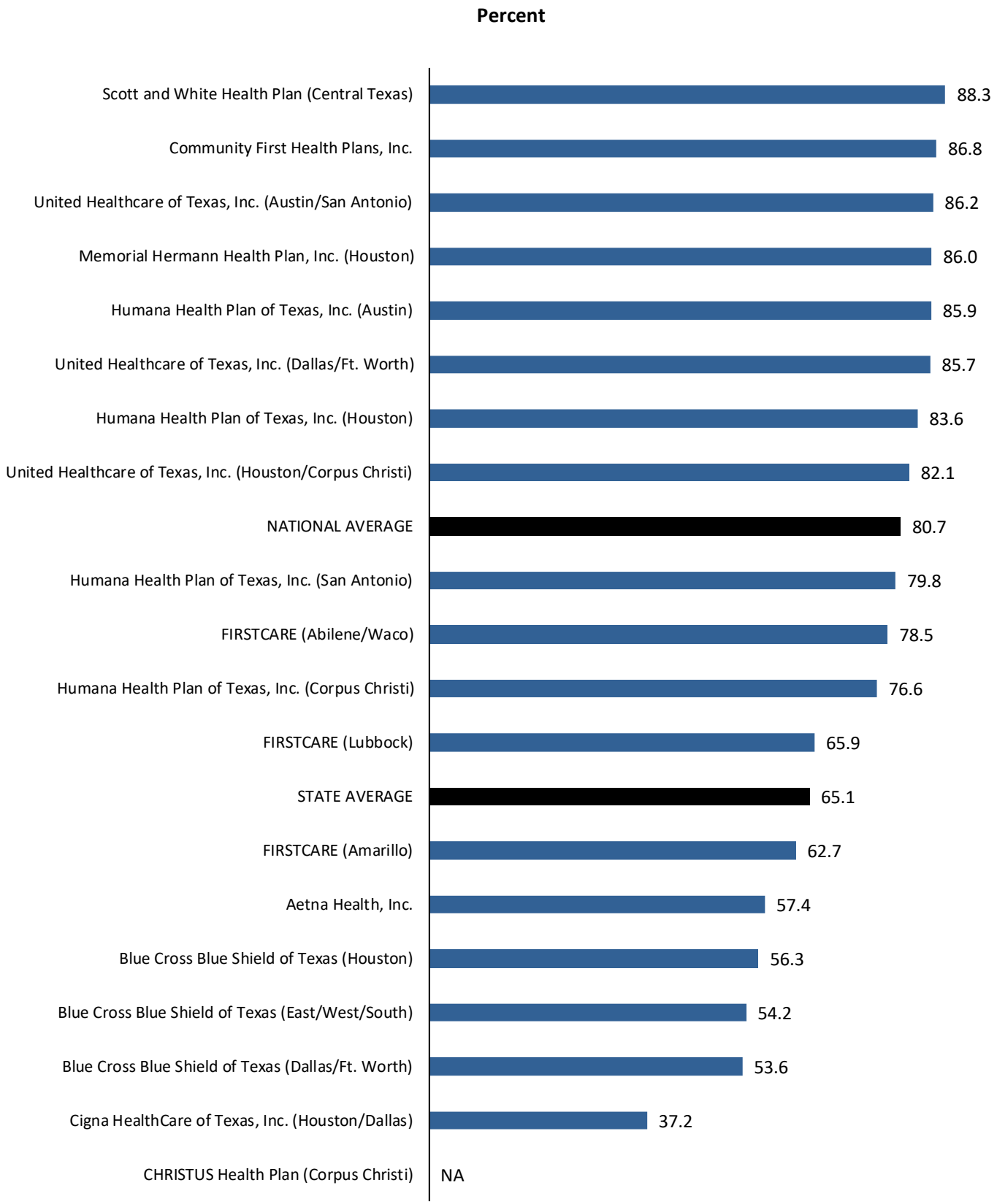
The American College of Obstetricians and Gynecologists (ACOG) recommends that a woman see her health care provider at least once 4-6 weeks after giving birth. The first postpartum visit should include a physical examination and is also an opportunity for the health care practitioner to answer questions, give family planning guidance, and counsel on nutrition.[1]

Postpartum Care					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	60.0%	56.4%	56.1%	59.1%	65.1%
NCQA's Quality Compass®	70.3%	74.1%	74.9%	74.9%	80.7%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

[1] American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. *Guidelines for Perinatal Care*. 7th ed. Washington, D.C.: American College of Obstetricians and Gynecologists, 2012.

Postpartum Care



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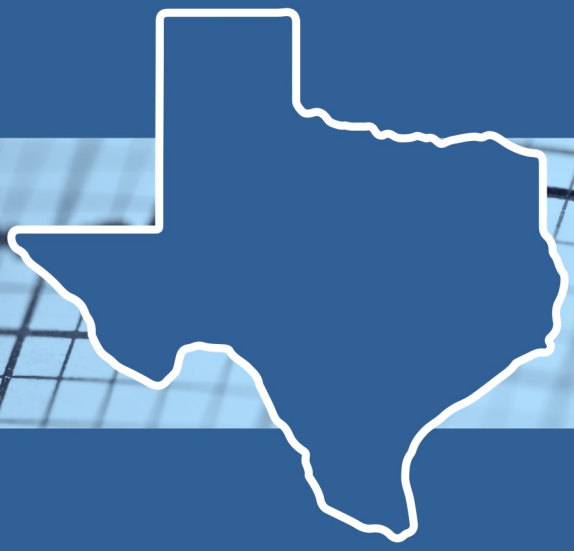


Section IV

Utilization and Risk Adjusted Utilization

Utilization and Risk Adjusted Utilization

Utilization

Well-Child Visits in the First 15 Months of Life: 6 or More Visits

DEFINITION:

The percentage of children who turned 15 months old during the measurement year and received 6 or more well-child visits with a primary care physician during those 15 months.

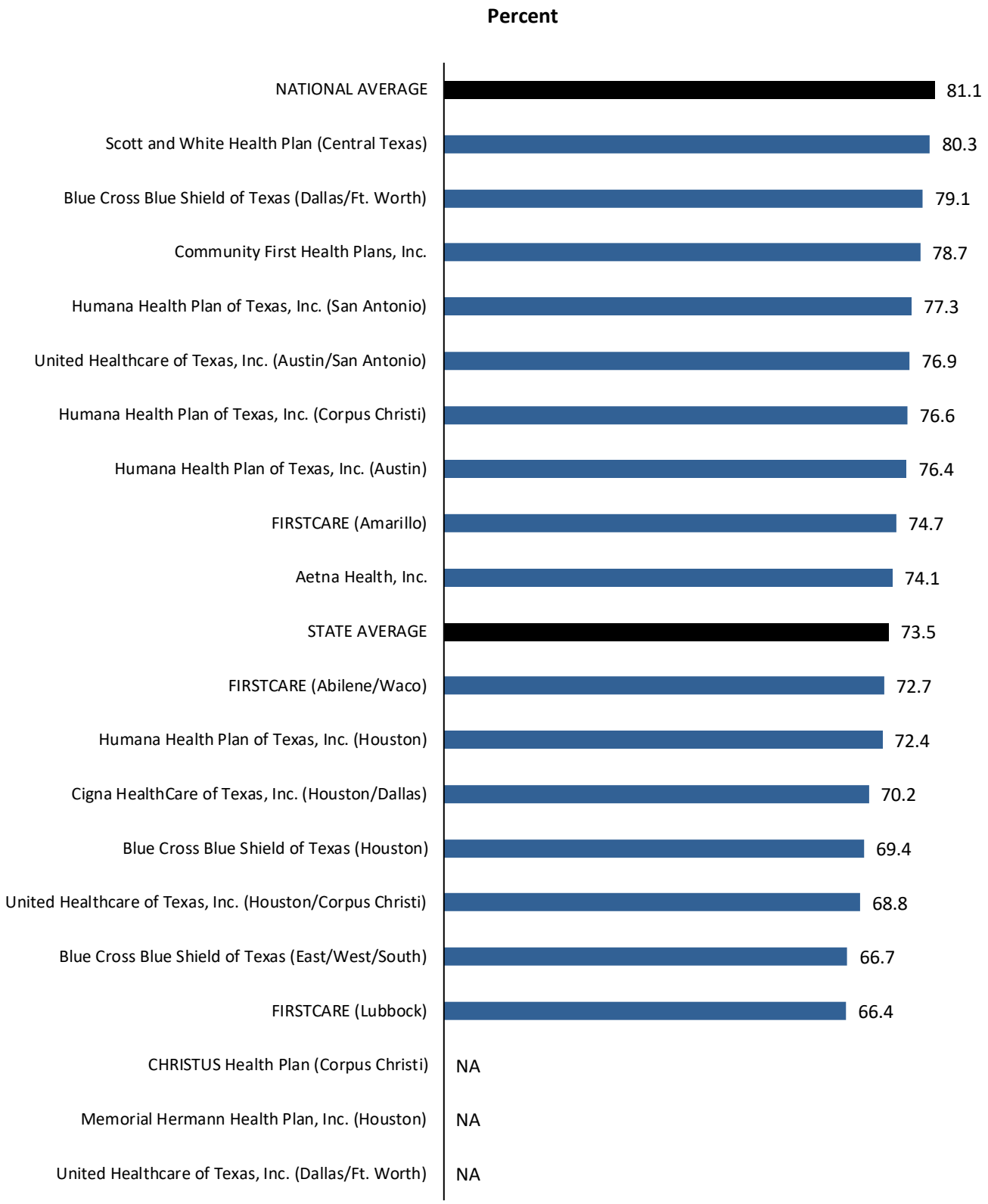
During the first year of life an infant undergoes substantial changes in abilities, physical growth, motor skills, hand-eye coordination, and social and emotional growth. Regular check-ups allow the clinician to detect and address physical, developmental, behavioral, and emotional problems in children. Well-child visits also provide an opportunity for the clinician to offer guidance and counseling to the parents. The American Academy of Pediatrics (AAP) recommends 6 well-child visits in the first year of life: 1 within the first month of life, and then at around 2, 4, 6, 9, and 12 months.[1]

Well-Child Visits in the First 15 Months of Life: 6 or More Visits					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	67.7%	71.9%	67.8%	74.1%	73.5%
NCQA's Quality Compass®	78.3%	79.2%	78.2%	79.8%	81.1%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.

[1] Hagen, Joseph F., Judith S. Shaw, and Paula M. Duncan, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics, 2008.

Well-Child Visits in the First 15 Months of Life: 6 or More Visits



NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

DEFINITION:

The percentage of children 3-6 years of age who received 1 or more well-child visits with a primary care physician during the measurement year.

Regular well-child visits during the preschool and early school years allow a clinician to detect vision, speech, and language problems. Early diagnosis and treatment can improve a child's communication skills and identify language and learning problems. The American Academy of Pediatrics (AAP) recommends at least 1 annual well-child visit for children 2-6 years of age.[1]

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	68.5%	71.3%	67.9%	72.5%	73.5%
NCQA's Quality Compass®	76.3%	76.8%	77.2%	79.0%	79.1%

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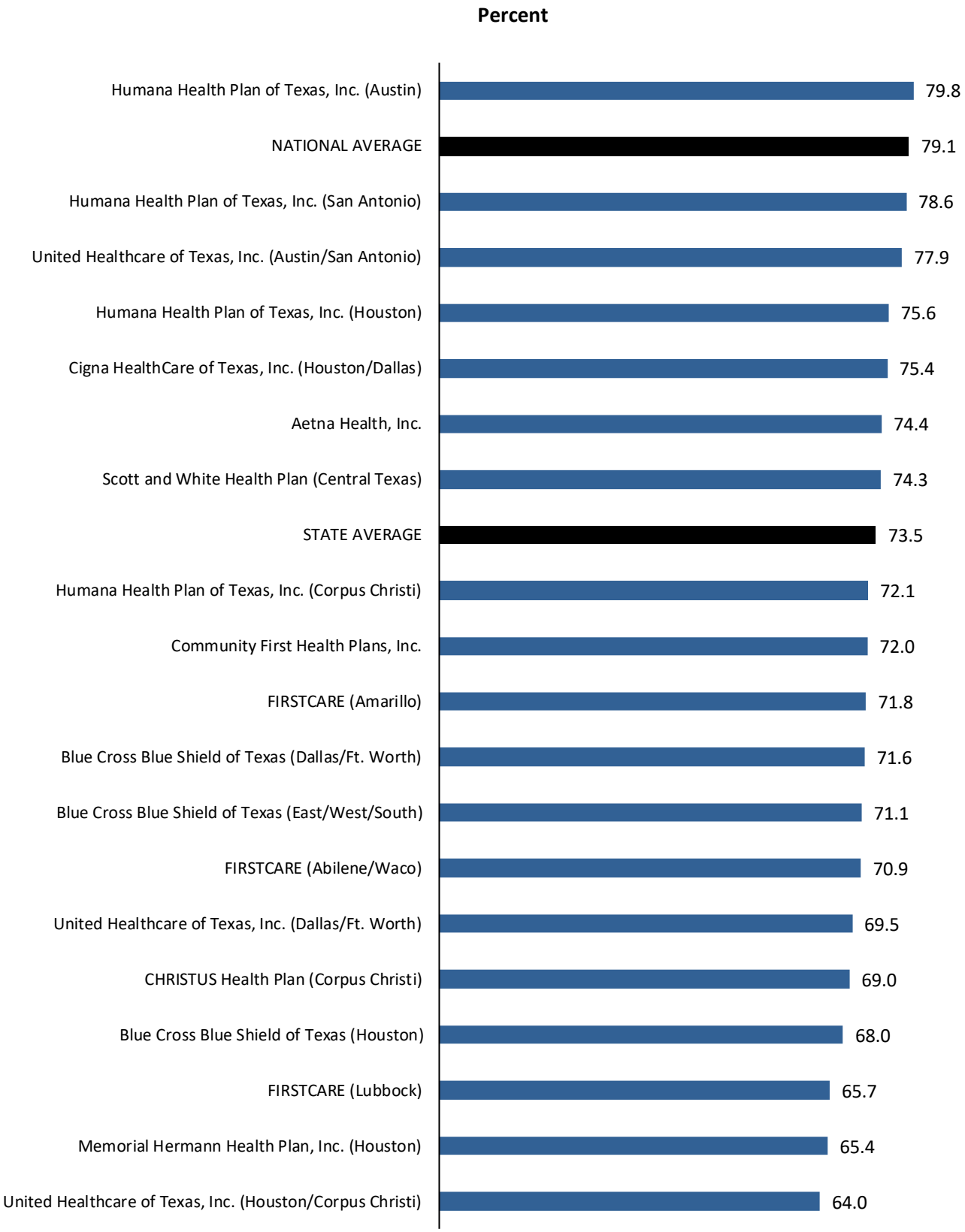
[1] Hagen, Joseph F., Judith S. Shaw, and Paula M. Duncan, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics, 2008.

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life



Adolescent Well-Care Visits

DEFINITION:

The percentage of enrolled members 12-21 years of age who had at least 1 comprehensive well-care visit with a primary care physician or an OB/GYN practitioner during the measurement year.

Adolescence is a time of transition between childhood and adult life. Adolescents benefit from an annual preventive health care visit that addresses the physical, emotional, and social aspects of their health. The American Academy of Pediatrics (AAP) recommends at least 1 annual well-care visit for healthy adolescents 12- 21 years of age.[1]

Adolescent Well-Care Visits					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	37.8%	42.2%	39.7%	42.6%	43.7%
NCQA's Quality Compass®	46.6%	47.7%	48.4%	50.3%	50.6%

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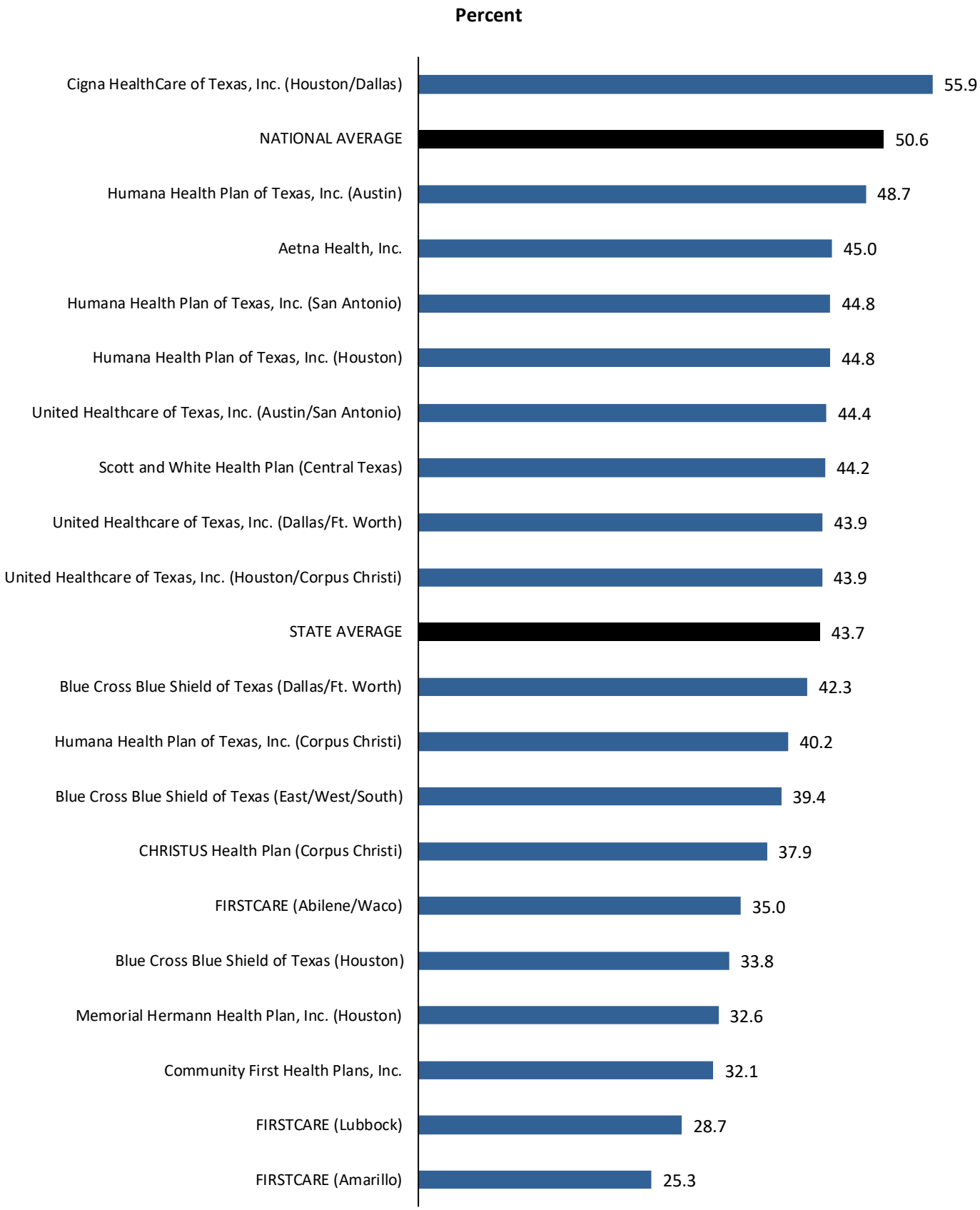
[1] Hagen, Joseph F., Judith S. Shaw, and Paula M. Duncan, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics, 2008.

Adolescent Well-Care Visits



Mental Health Utilization: Percentage of Members Receiving Mental Health Services

DEFINITION:

The percentage of members with a mental health benefit receiving any mental health services (inpatient, intensive outpatient or partial hospitalization, outpatient, emergency department [ED] and telehealth mental health services).

Mental illness can range in impact from mild impairment to significantly disabling impairment, such as in individuals with serious mental illness. Serious mental illness is defined as individuals with a mental disorder with serious functional impairment which substantially interferes with or limits 1 or more major life activities. This includes all adults who received care in inpatient or outpatient settings and/or used prescription medication for mental or emotional problems.

Mental Health Utilization: Percentage of Members Receiving Mental Health Services

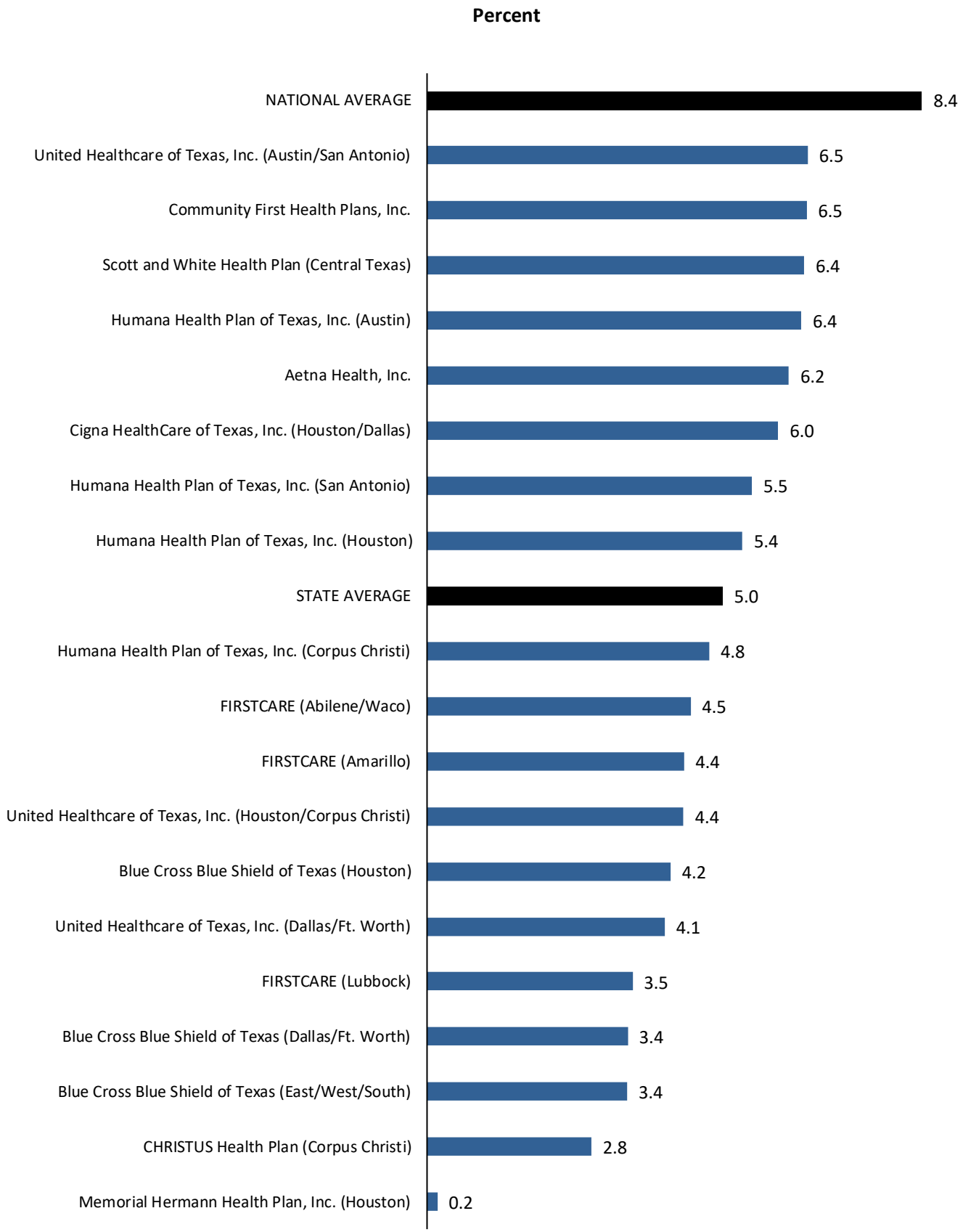
Mental Health Services Received	2016		2017		2018		2019		2020	
	TX	QC	TX	QC	TX	QC	TX	QC	TX	QC
Any	4.1%	6.6%	4.2%	6.6%	4.9%	7.0%	5.0%	7.7%	5.0%	8.4%
Inpatient	0.19%	0.24%	0.21%	0.23%	0.10%	0.10%	0.22%	0.26%	0.21%	0.26%
Intensive Outpatient or Partial Hospitalization	0.09%	0.18%	0.09%	0.19%	0.03%	0.10%	0.08%	0.17%	0.09%	0.19%
Outpatient	4.0%*	6.5%*	4.1%*	6.5%*	4.8%	6.8%	4.9%	7.6%	4.9%	8.3%
ED					0.04%	0.10%	0.07%	0.09%	0.02%	0.08%
Telehealth	**	**	**	**	0.02%	0.00%	0.05%	0.05%	0.11%	0.12%

Quality Compass® (QC) is a national database of health plan-specific performance information voluntarily reported to the NCQA.

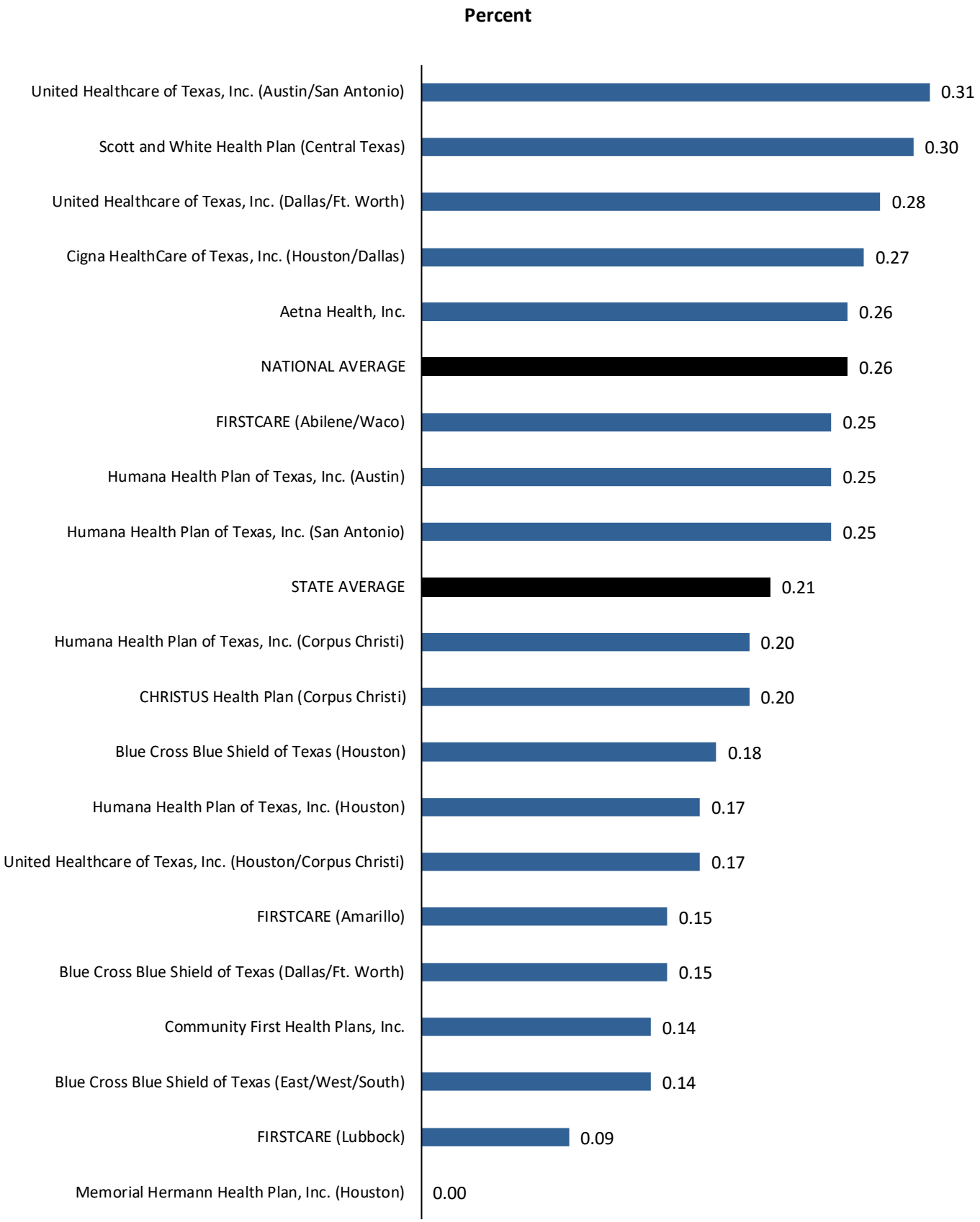
*Components divided into separate measures in 2018.

**New measure added in 2018.

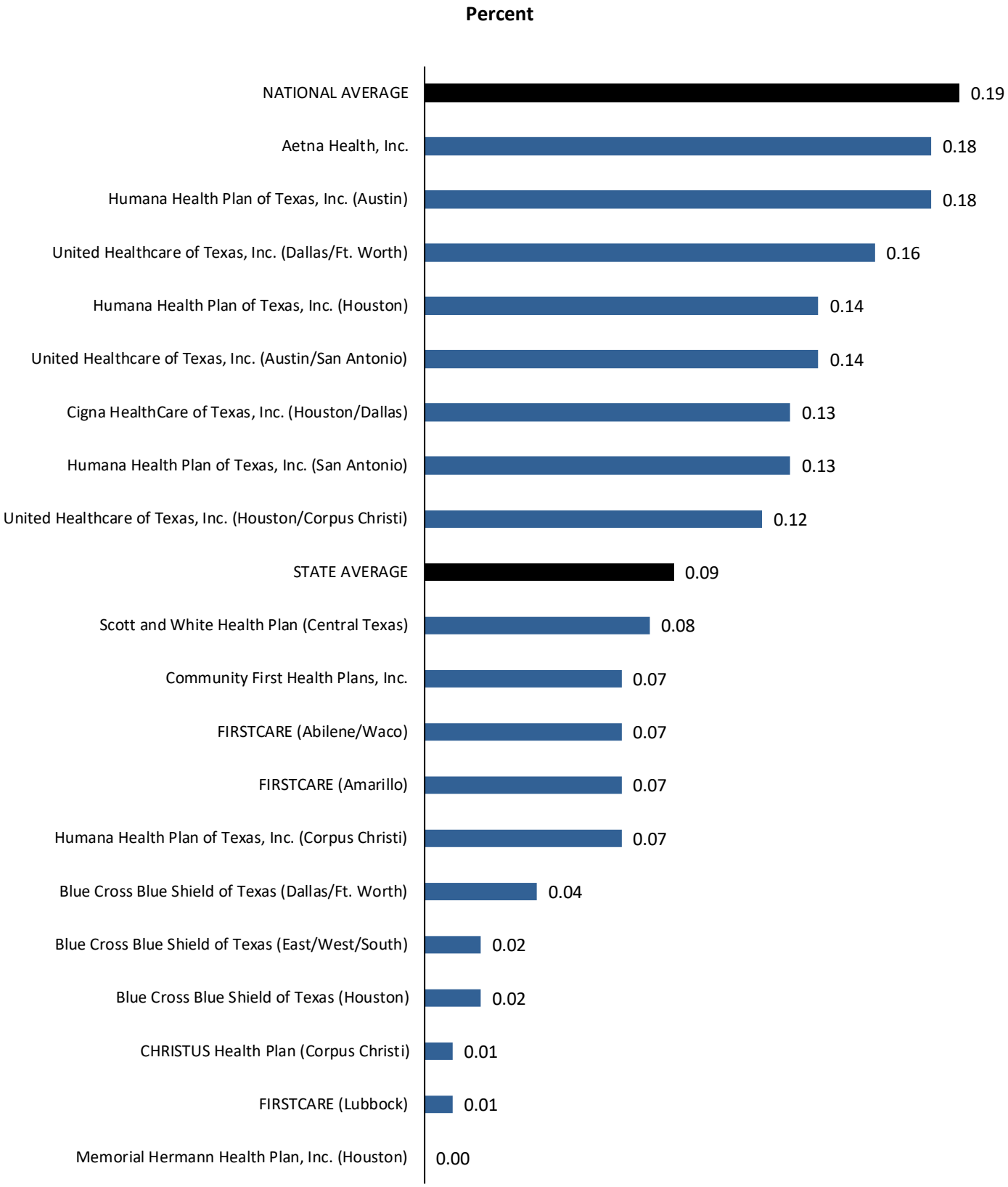
Mental Health Utilization: Any Services



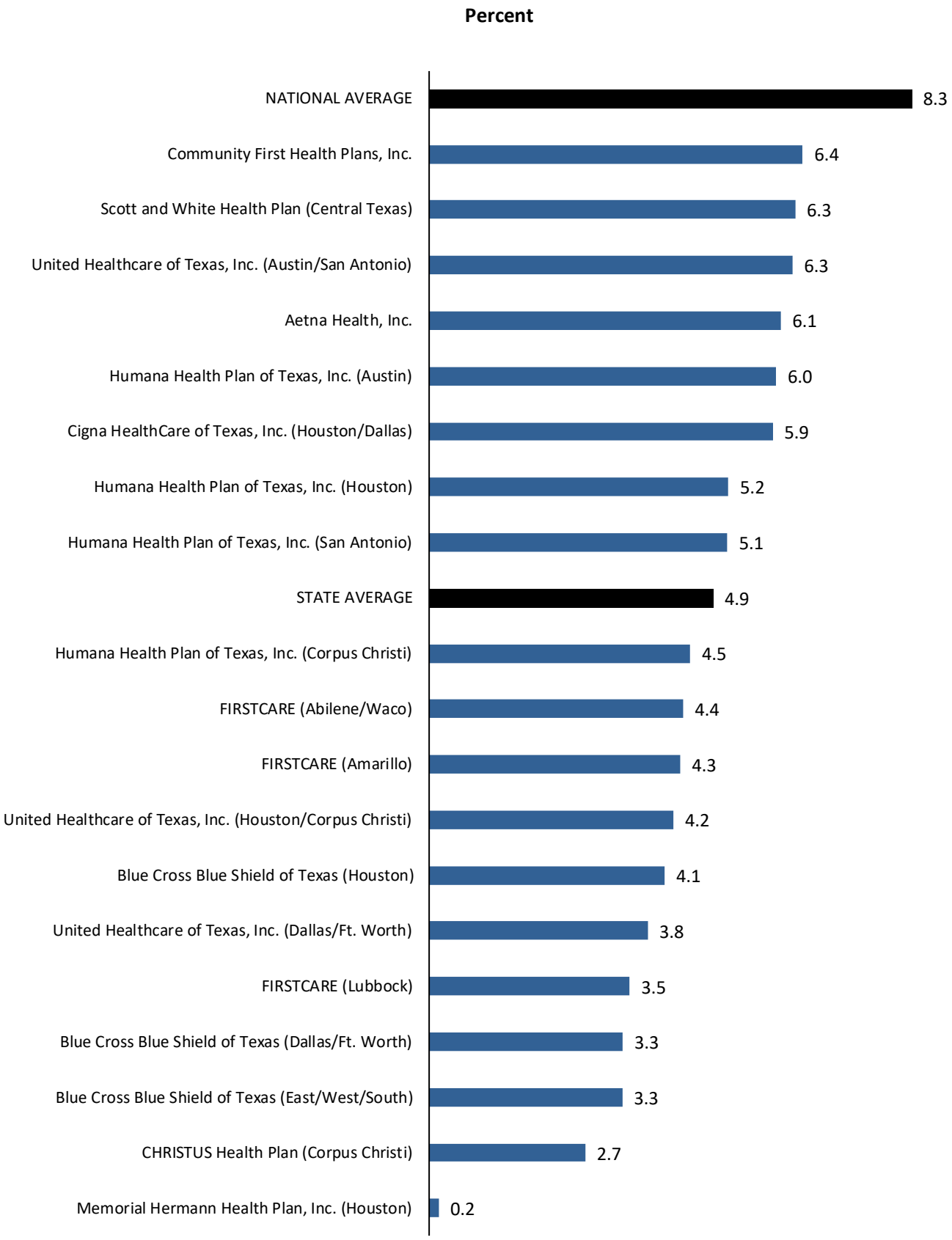
Mental Health Utilization: Inpatient Services



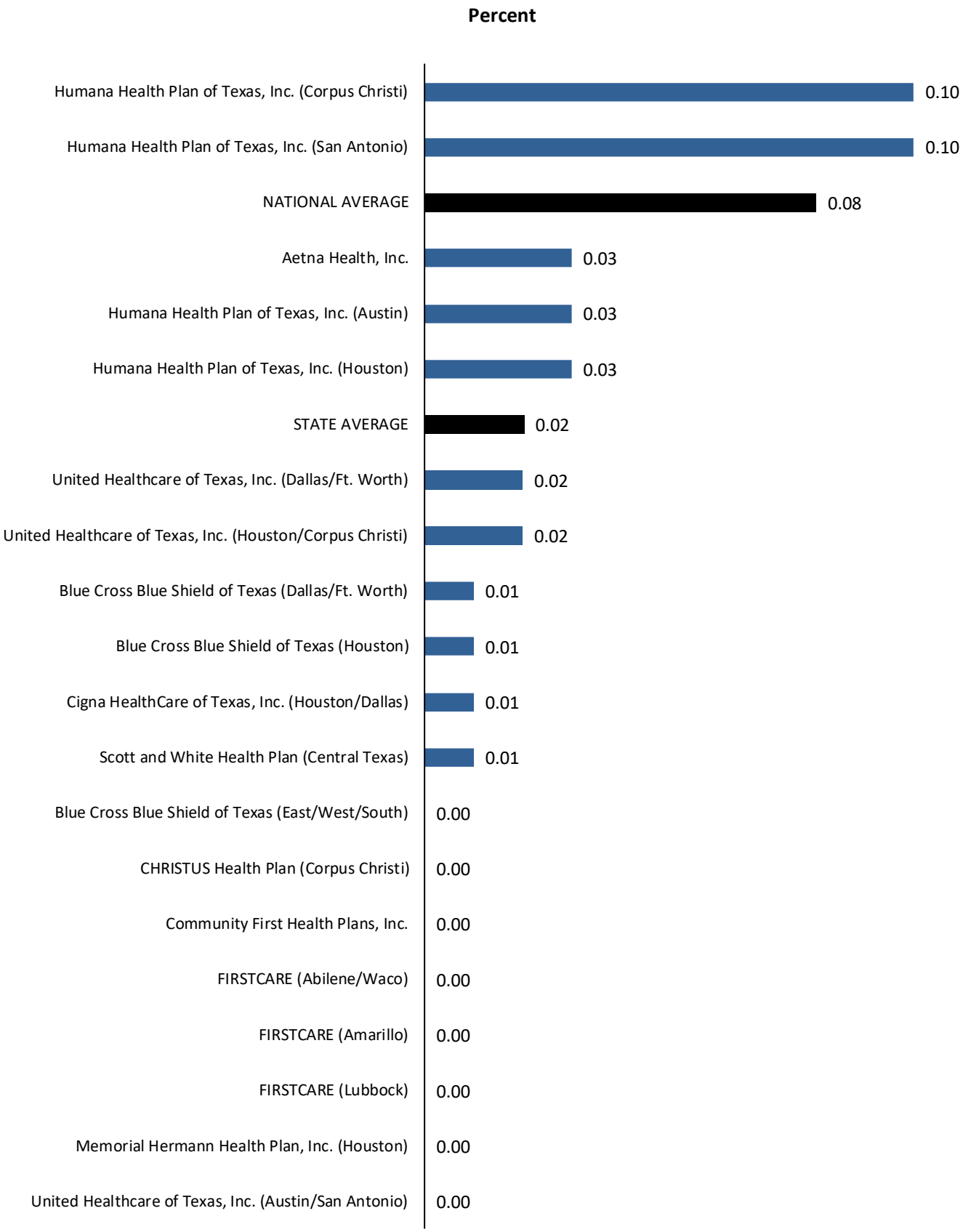
Mental Health Utilization:
Intensive Outpatient or Partial Hospitalization



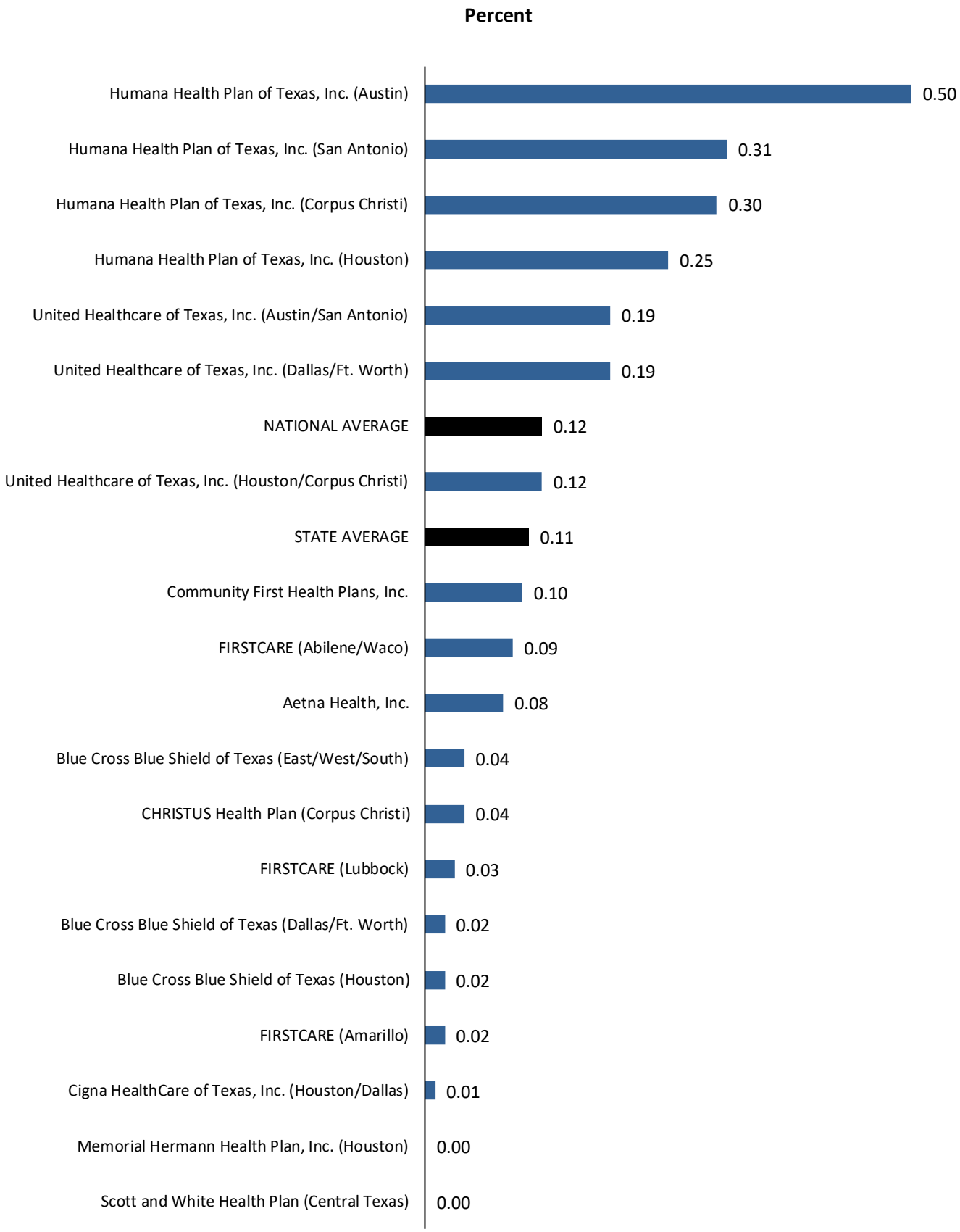
Mental Health Utilization: Outpatient Services



Mental Health Utilization: ED



Mental Health Utilization: Telehealth



Antibiotic Utilization

DEFINITION:

The average number of antibiotic prescriptions per member per year (PMPY), the average days supplied for all antibiotic prescriptions, the average number of antibiotic prescriptions PMPY for antibiotics of concern, and the percentage of antibiotics of concern prescribed during the measurement year for outpatient utilization.

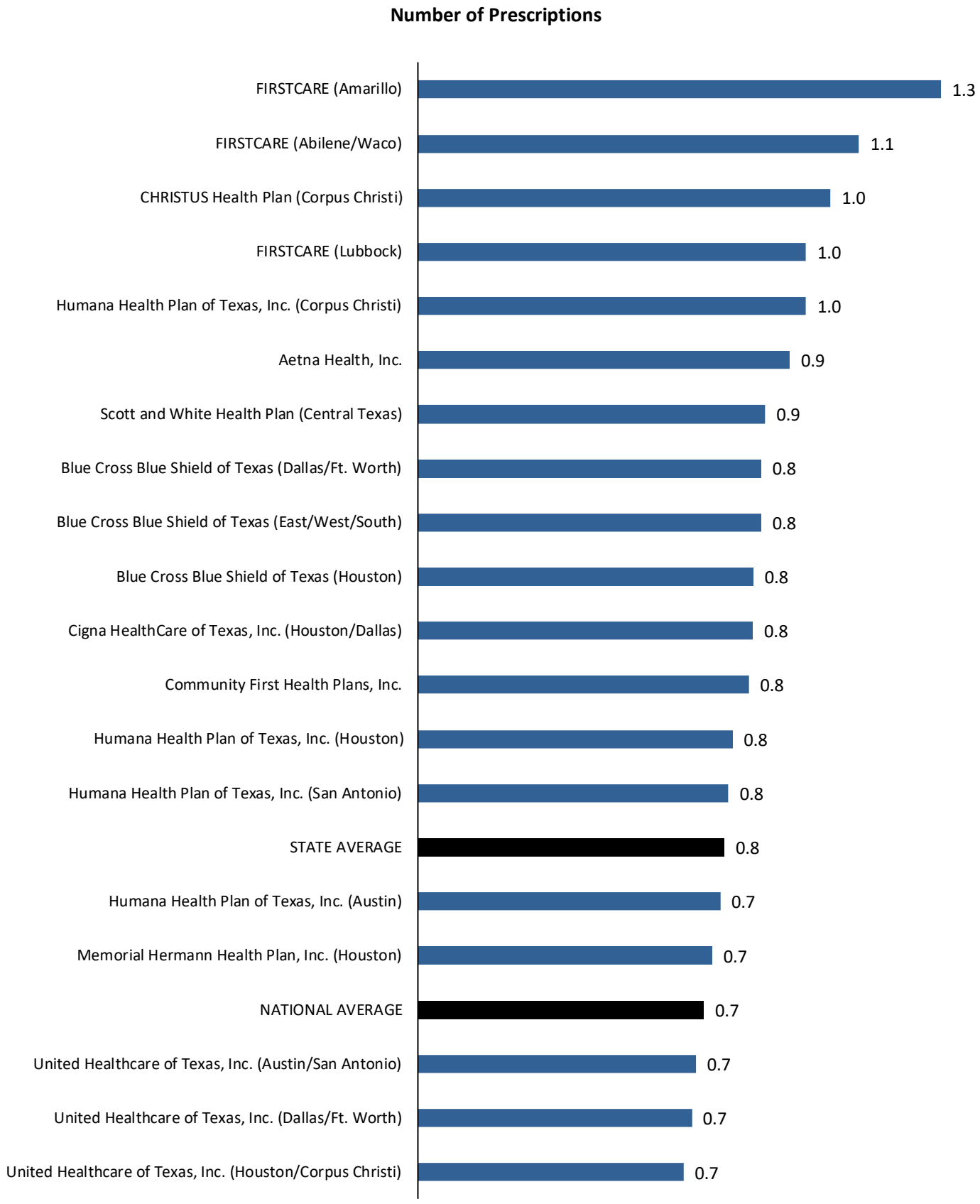
The use of antibiotics for an organization's total population provides a comprehensive picture of trends in antibiotic prescribing.

Antibiotic Utilization										
	2016		2017		2018		2019		2020	
	TX	QC	TX	QC	TX	QC	TX	QC	TX	QC
Avg. # Antibiotic Prescriptions PMPY	0.9	0.8	0.8	0.8	0.7	**	0.8	0.7	0.8	0.7
Avg. Days Supplied Per Antibiotic Prescription	9.7	10.2	9.5	10.1	9.6	**	9.5	10.0	9.6	10.0
Avg. # of Prescriptions for Antibiotics of Concern PMPY	0.5	0.4	0.4	0.4	0.4	**	0.4	0.3	0.4	0.3
% of Antibiotics of Concern for all Antibiotic Prescriptions	52.9%	49.4%	52.2%	48.4%	49.3%	**	50.6%	45.2%	50.0%	44.6%

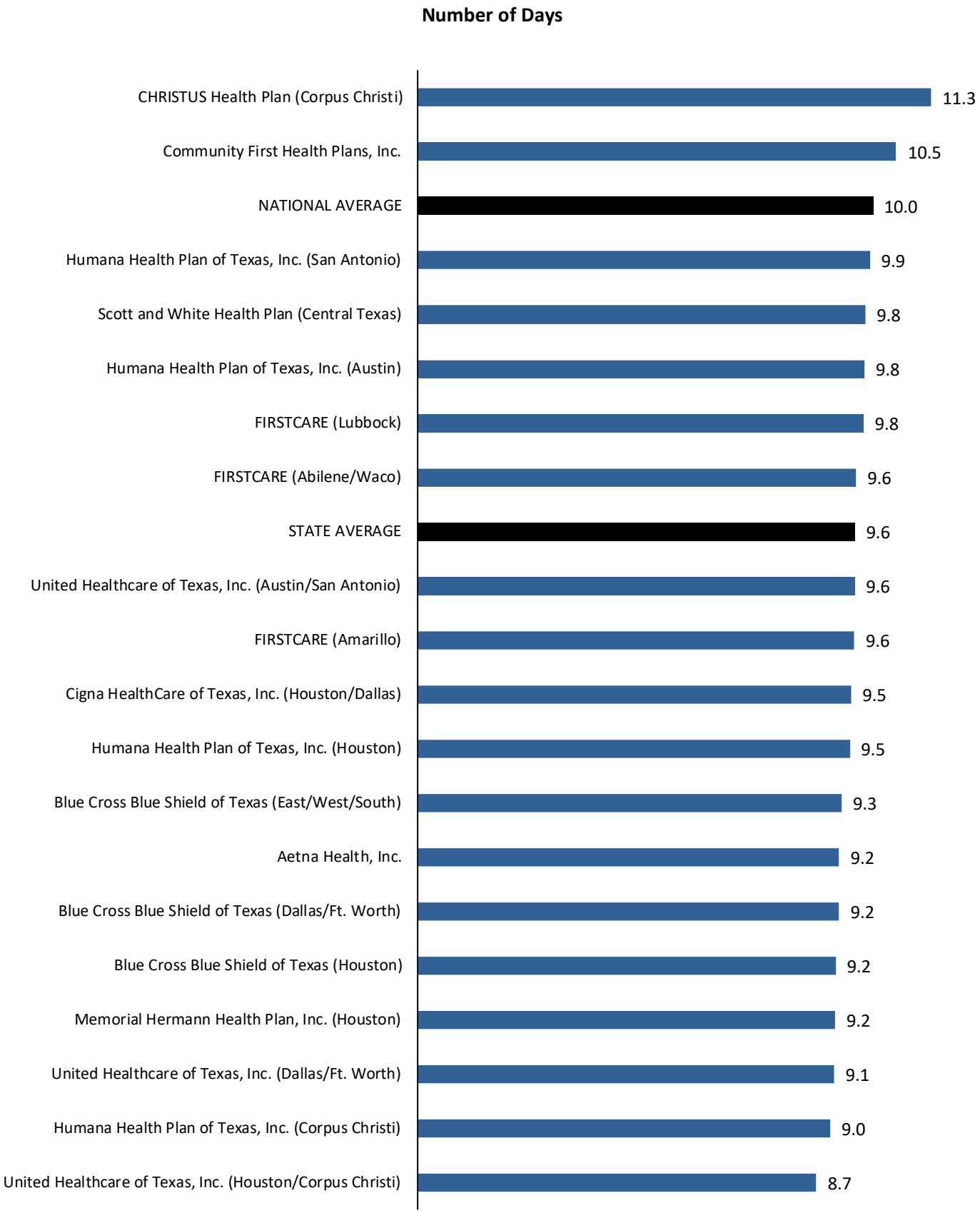
Quality Compass® (QC) is a national database of health plan-specific performance information voluntarily reported to the NCQA.

**Value not established or not obtained.

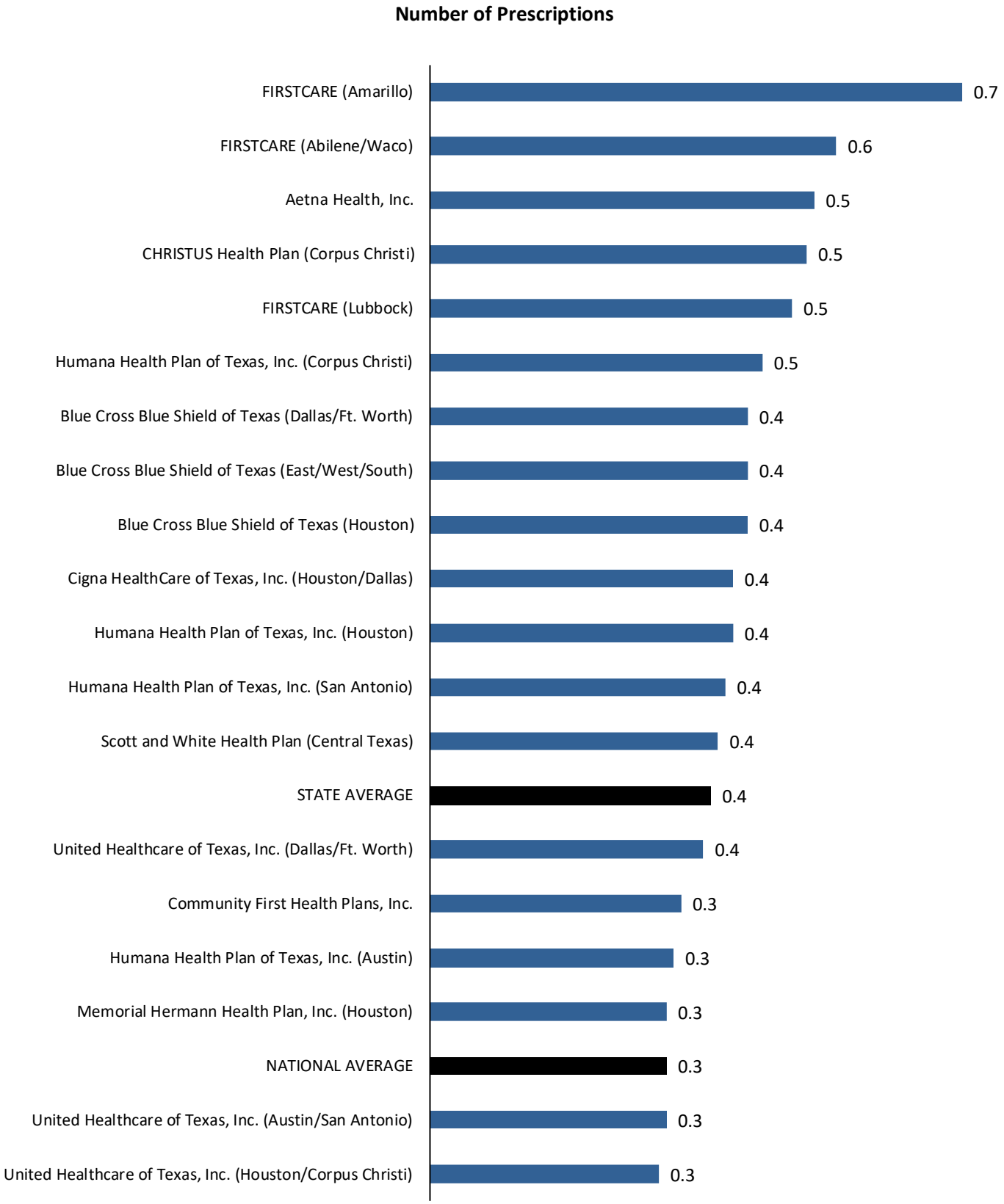
Average Number of Prescriptions PMPY



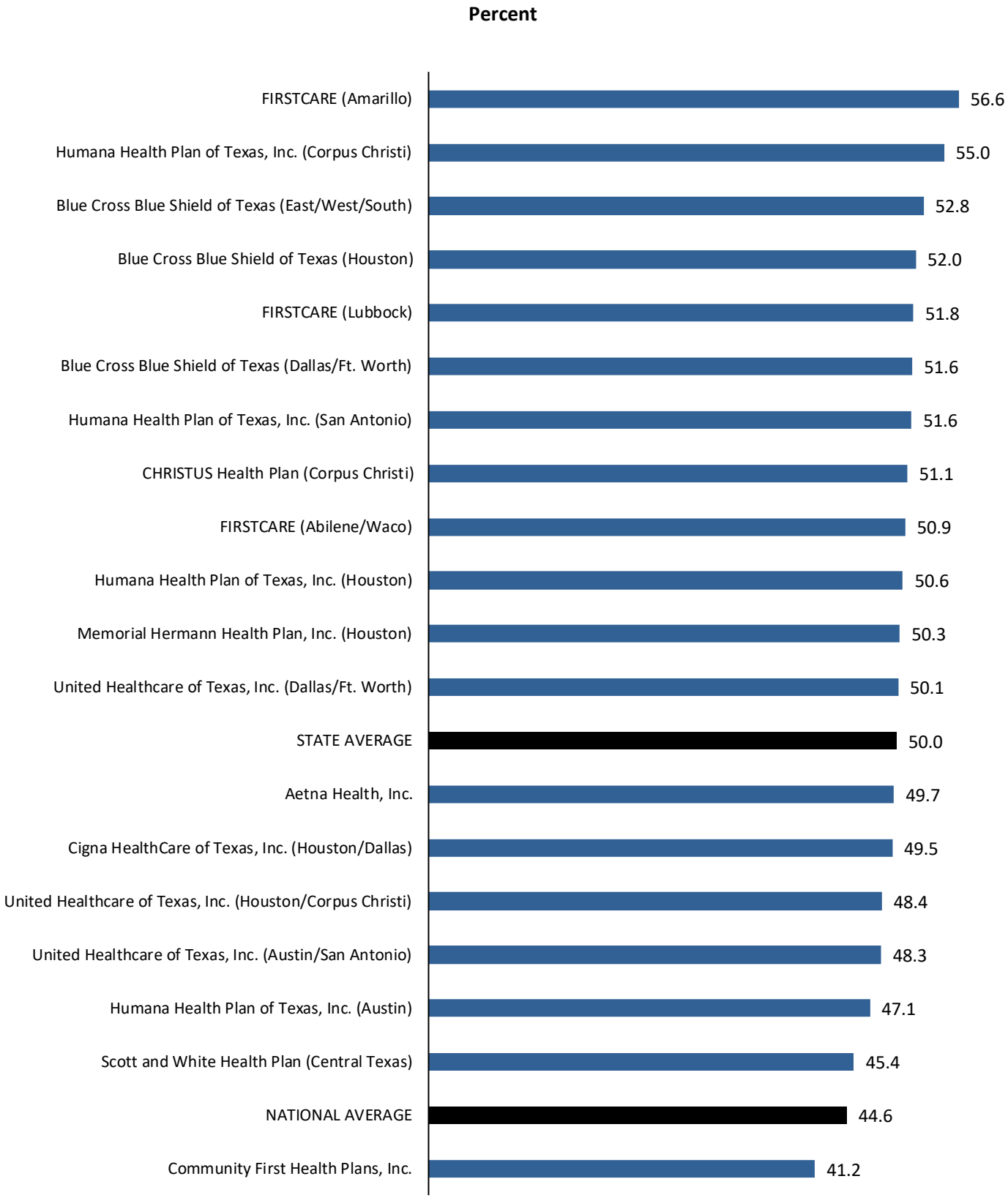
Average Days Supplied Per Antibiotic Prescription



Average Number of Prescriptions for Antibiotics of Concern PMPY



Percentage of Antibiotics of Concern For All Antibiotic Prescriptions



Utilization and Risk Adjusted Utilization

Risk Adjusted Utilization

Acute Hospital Utilization

DEFINITION:

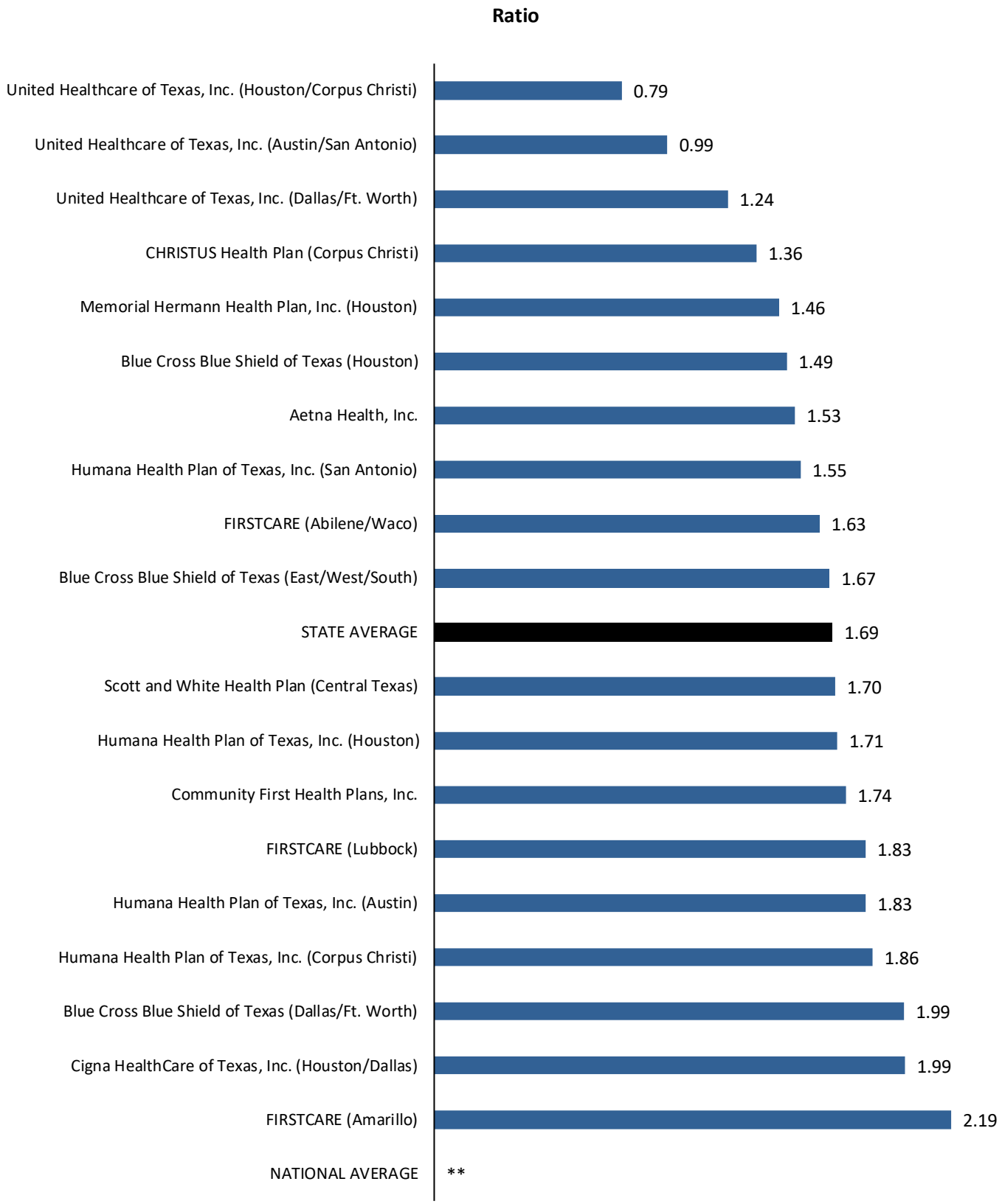
For members 18 years of age and older, the risk-adjusted ratio of observed-to-expected acute inpatient and observation stay discharges during the measurement year reported by Surgery, Medicine, and Total.

**Note: Lower rates indicate better performance for this measure.*
This measure was added to the Texas Subset beginning with HEDIS® 2020.

Acute Hospital Utilization: Ratio of Observed to Expected Visits										
	2016		2017		2018		2019		2020	
	TX	QC	TX	QC	TX	QC	TX	QC	TX	QC
Surgery	**	**	**	**	**	**	**	**	1.69	**
Medicine	**	**	**	**	**	**	**	**	0.96	0.90
Total Acute	**	**	**	**	**	**	**	**	1.15	1.08

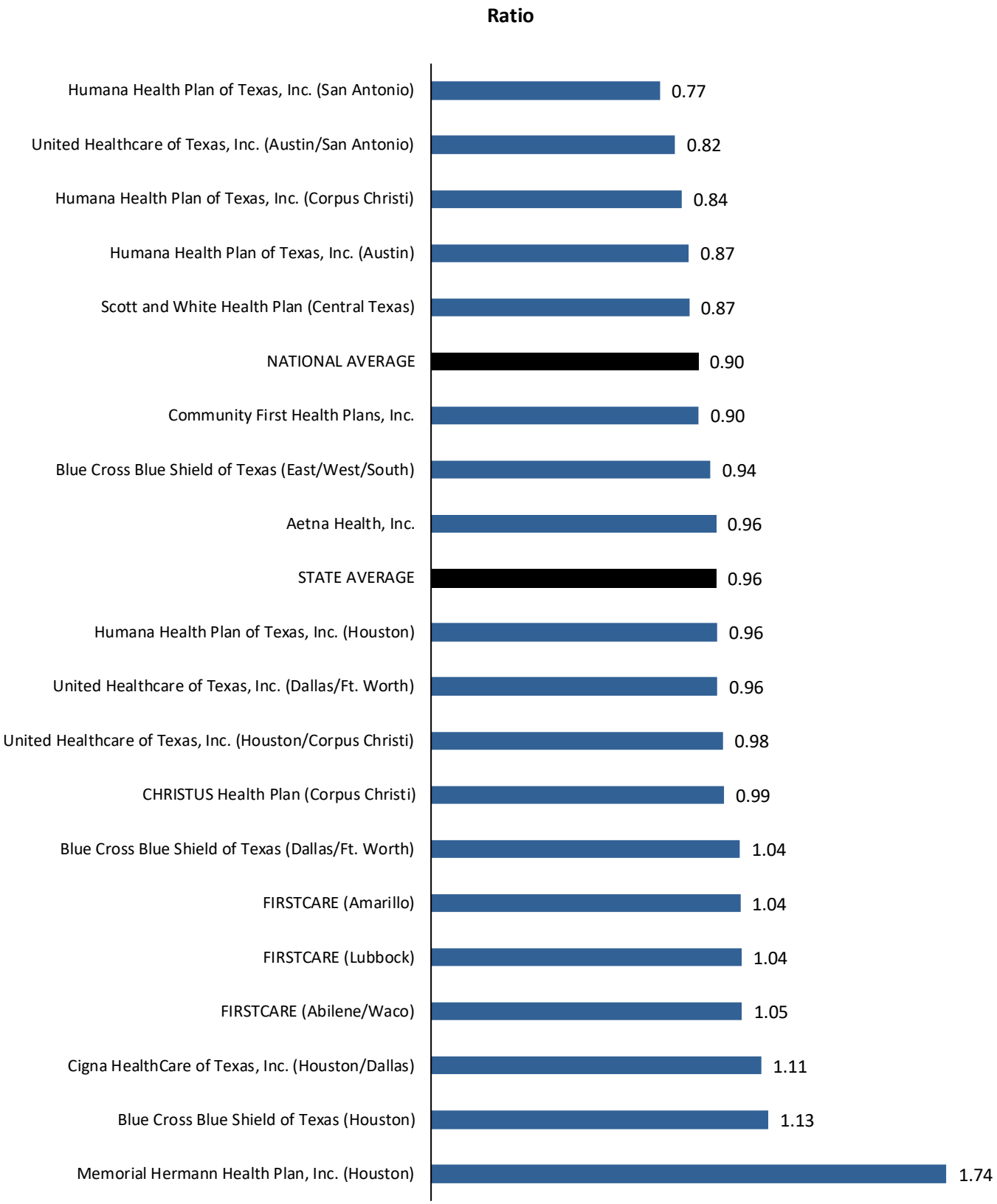
Quality Compass® (QC) is a national database of health plan-specific performance information voluntarily reported to the NCQA.
**Value not established or not obtained.

Ratio of Observed to Expected Visits: Surgery



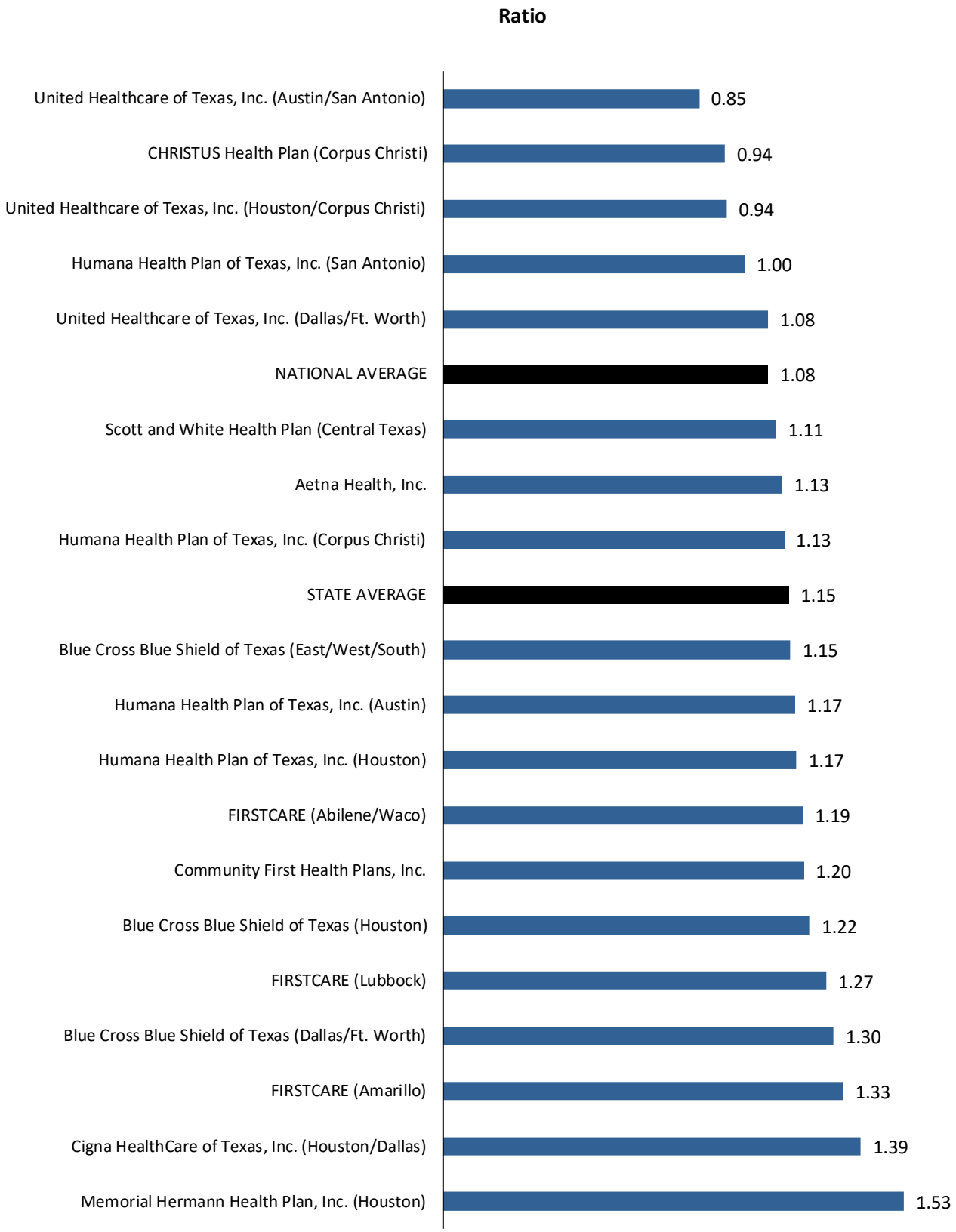
Note: Lower rates indicate better performance for this measure.
*** Value not established or not obtained.*

Ratio of Observed to Expected Visits: Medicine



Note: Lower rates indicate better performance for this measure.

Ratio of Observed to Expected Visits: Total Acute



Note: Lower rates indicate better performance for this measure.

Emergency Department Utilization

DEFINITION:

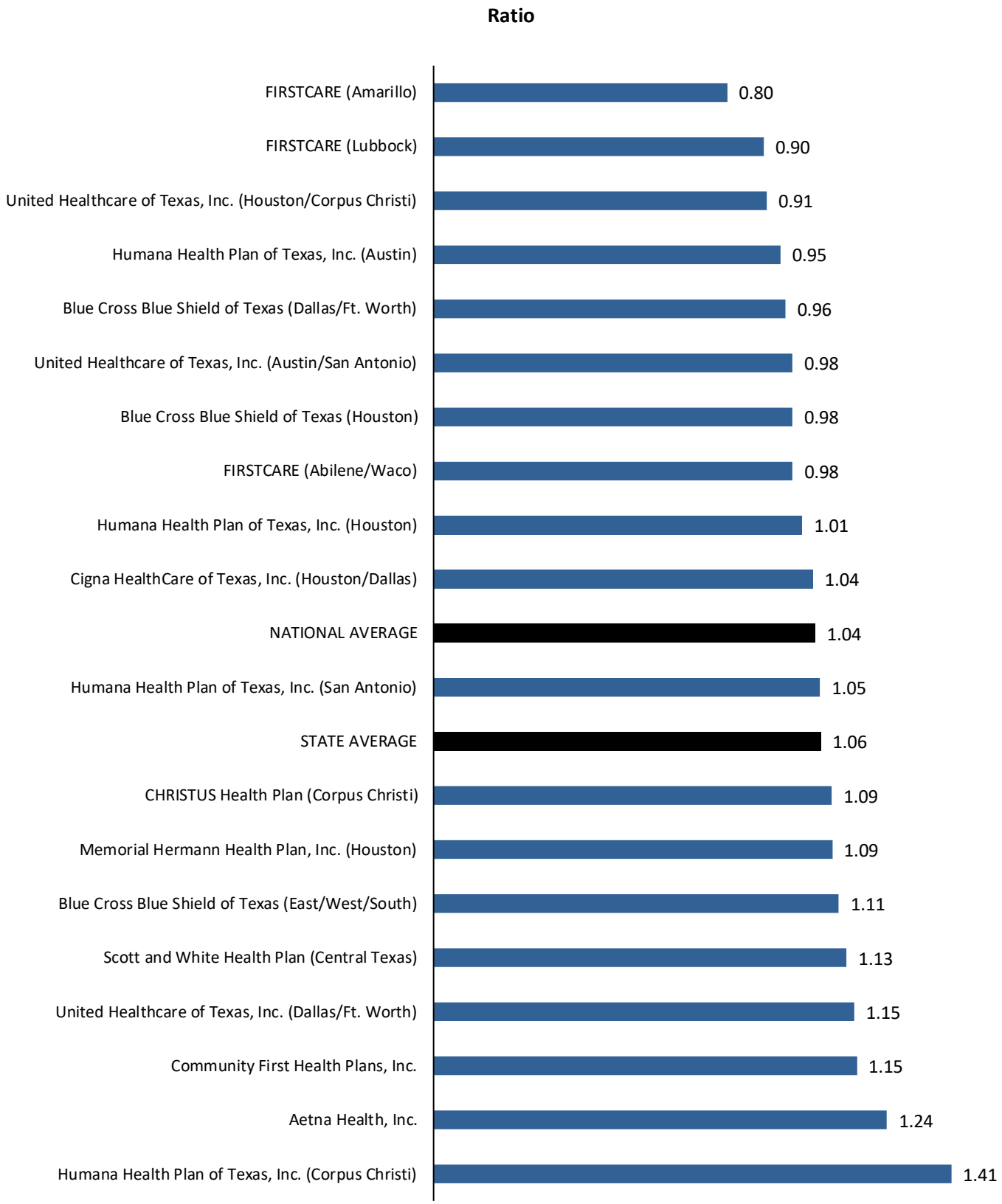
For members 18 years of age and older, this measure assesses the risk-adjusted ratio of observed to expected emergency department (ED) visits during the measurement year. This allows better comparison of inpatient use across health plans by removing the effect of select patient characteristics and health status differences on the reported results.

**Note: Lower rates indicate better performance for this measure.*
This measure was added to the Texas Subset beginning with HEDIS® 2018.

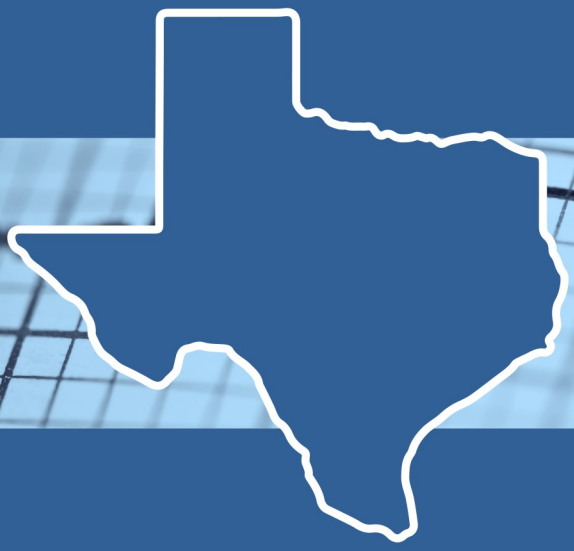
Ratio of Observed to Expected Emergency Department Visits: Total					
	2016	**2017**	**2018**	**2019**	**2020**
Texas Average	**	**	1.07	1.06	1.06
NCQA's Quality Compass®	**	**	1.10	1.05	1.04

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.
**Value not established or not obtained.

Ratio of Observed to Expected Visits: Total



Note: Lower rates indicate better performance for this measure.



Section V

Health Plan Descriptive Information

Board Certification

DEFINITION:

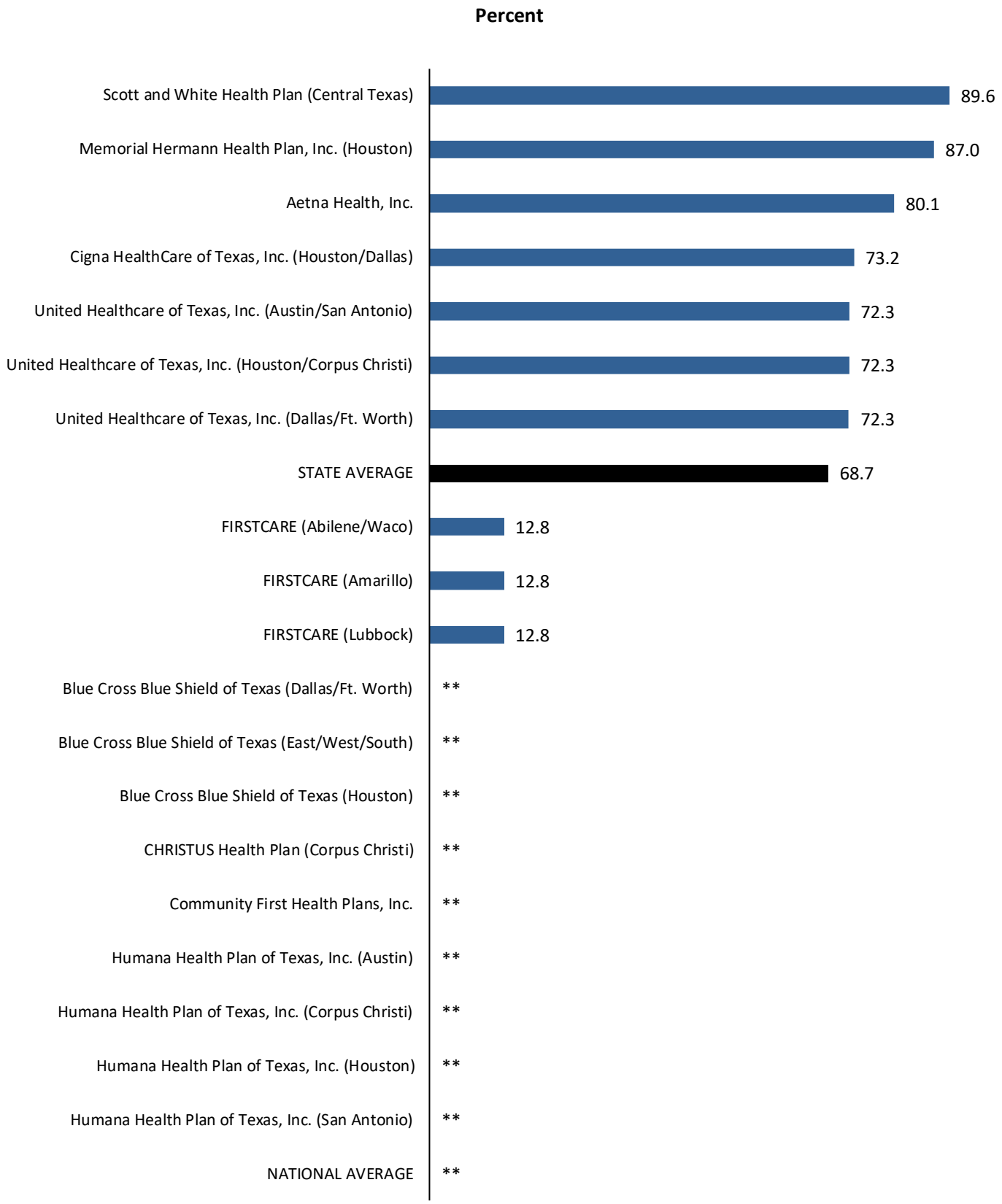
The percentage of physicians whose board certification is active as of December 31st of the measurement year.

Board-certified physicians have completed residency training and a certification program in their specific field of practice. The percentage of board-certified physicians in each plan does not directly measure the quality of every doctor in the plan. However, it does provide basic information about the credentials of the plan's physicians.

Physicians with Board Certification										
	2016		2017		2018		2019		2020	
	TX	QC	TX	QC	TX	QC	TX	QC	TX	QC
Family Medicine Physicians	58.9%	**	57.4%	**	60.3%	**	66.5%	**	68.7%	**
Internal Medicine Physicians	67.9%	**	66.7%	**	70.2%	**	72.2%	**	74.3%	**
OB/GYNs	74.8%	**	74.6%	**	75.1%	**	79.2%	**	82.4%	**
Pediatricians	78.2%	**	79.3%	**	83.2%	**	84.8%	**	83.5%	**
Geriatricians	26.9%	**	25.6%	**	35.4%	**	42.7%	**	60.3%	**
Other Physician Specialists	66.5%	**	63.5%	**	63.5%	**	68.1%	**	73.0%	**

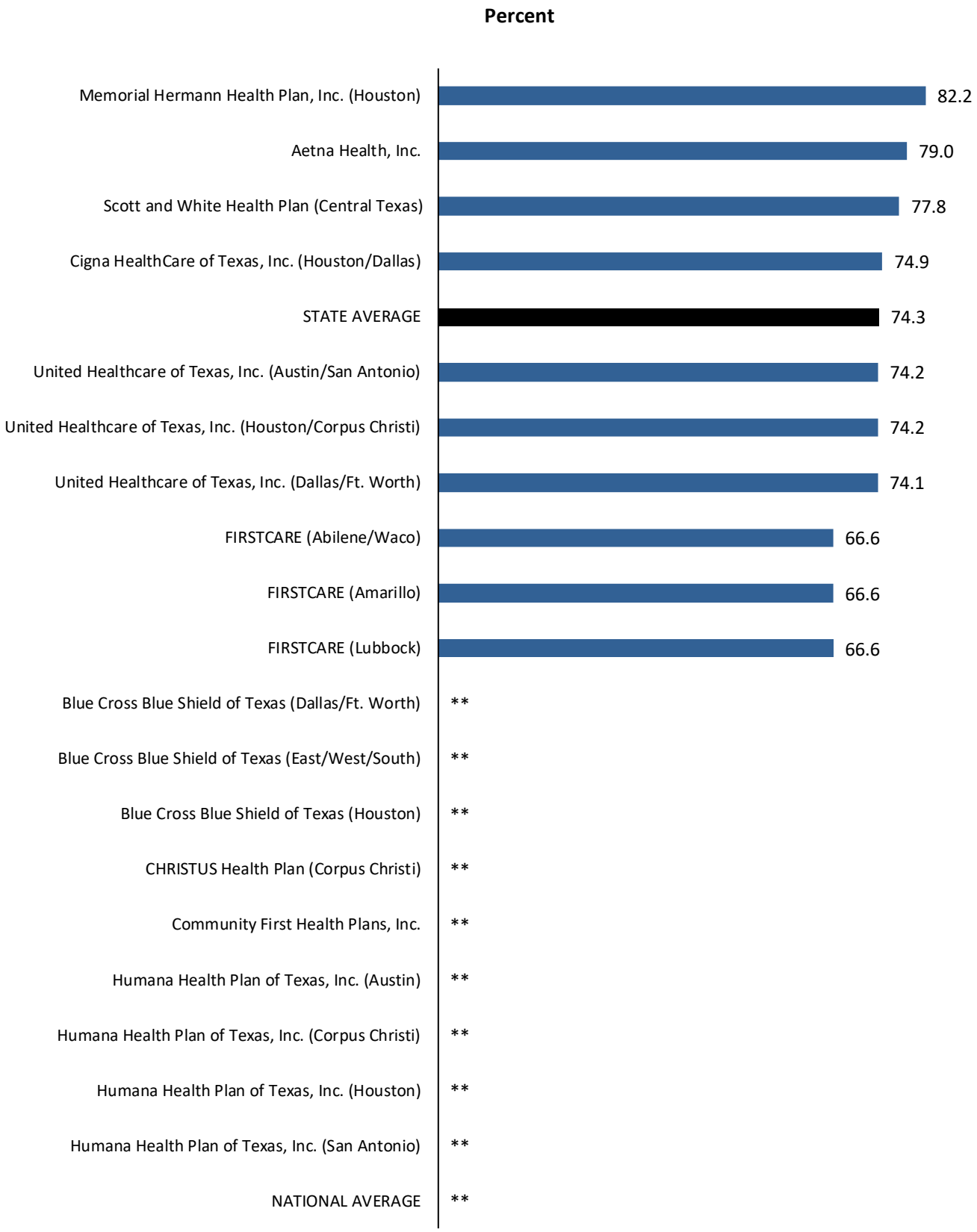
Quality Compass® (QC) is a national database of health plan-specific performance information voluntarily reported to the NCQA.
**Value not established or not obtained.

Board Certification: Family Medicine Physicians



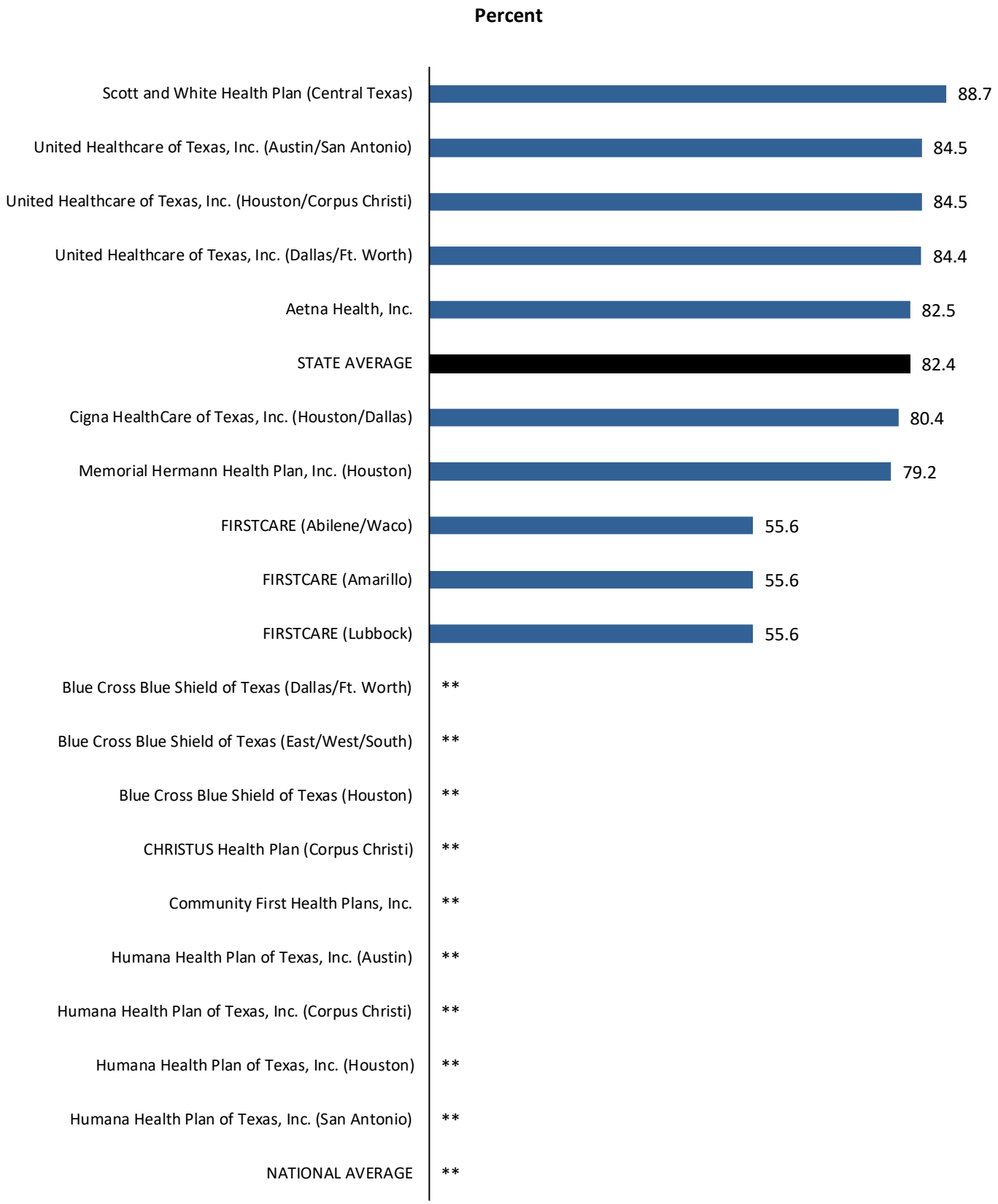
*** Value not established or obtained.*

Board Certification: Internal Medicine Physicians



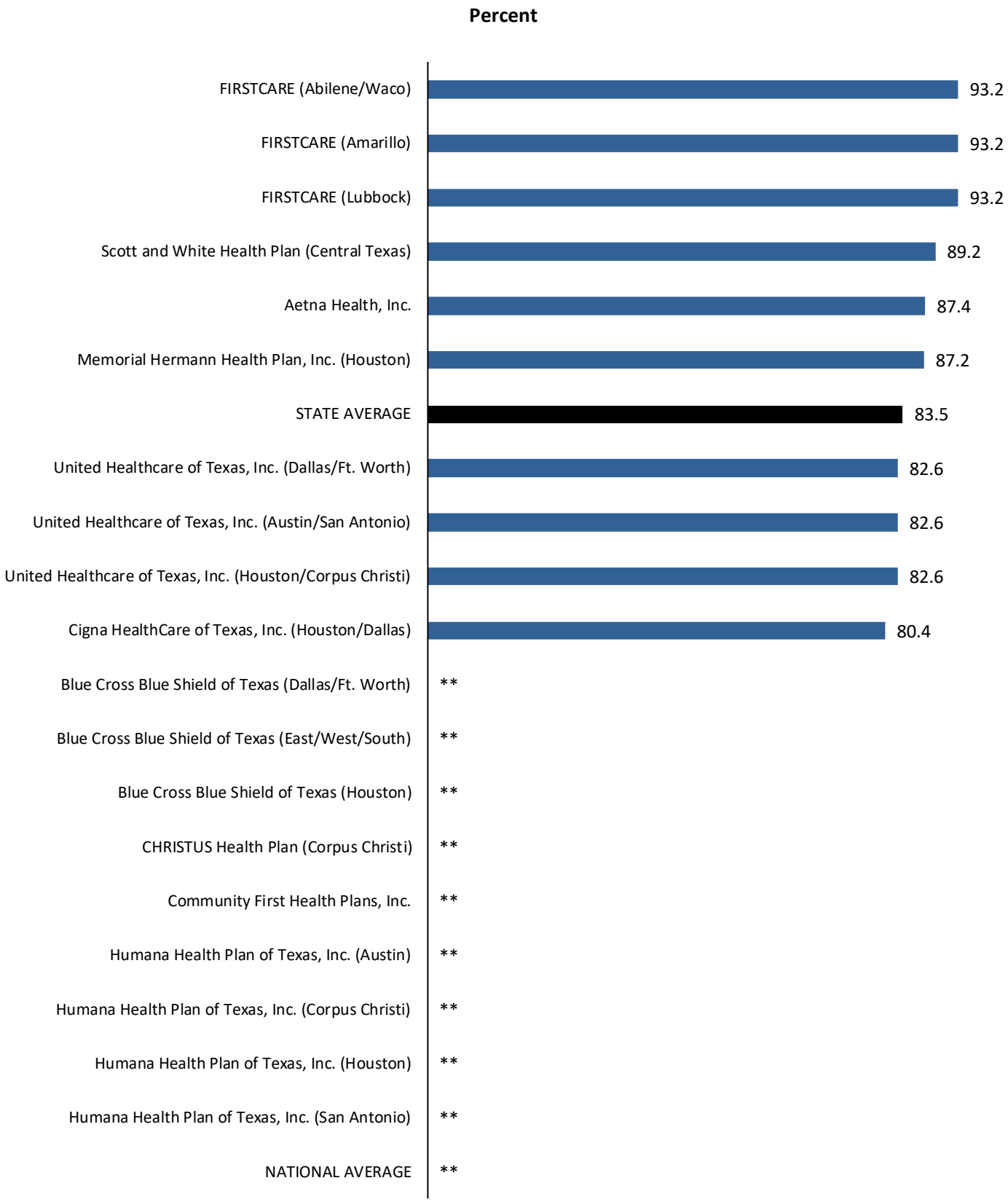
*** Value not established or obtained.*

Board Certification: OB/GYN Physicians



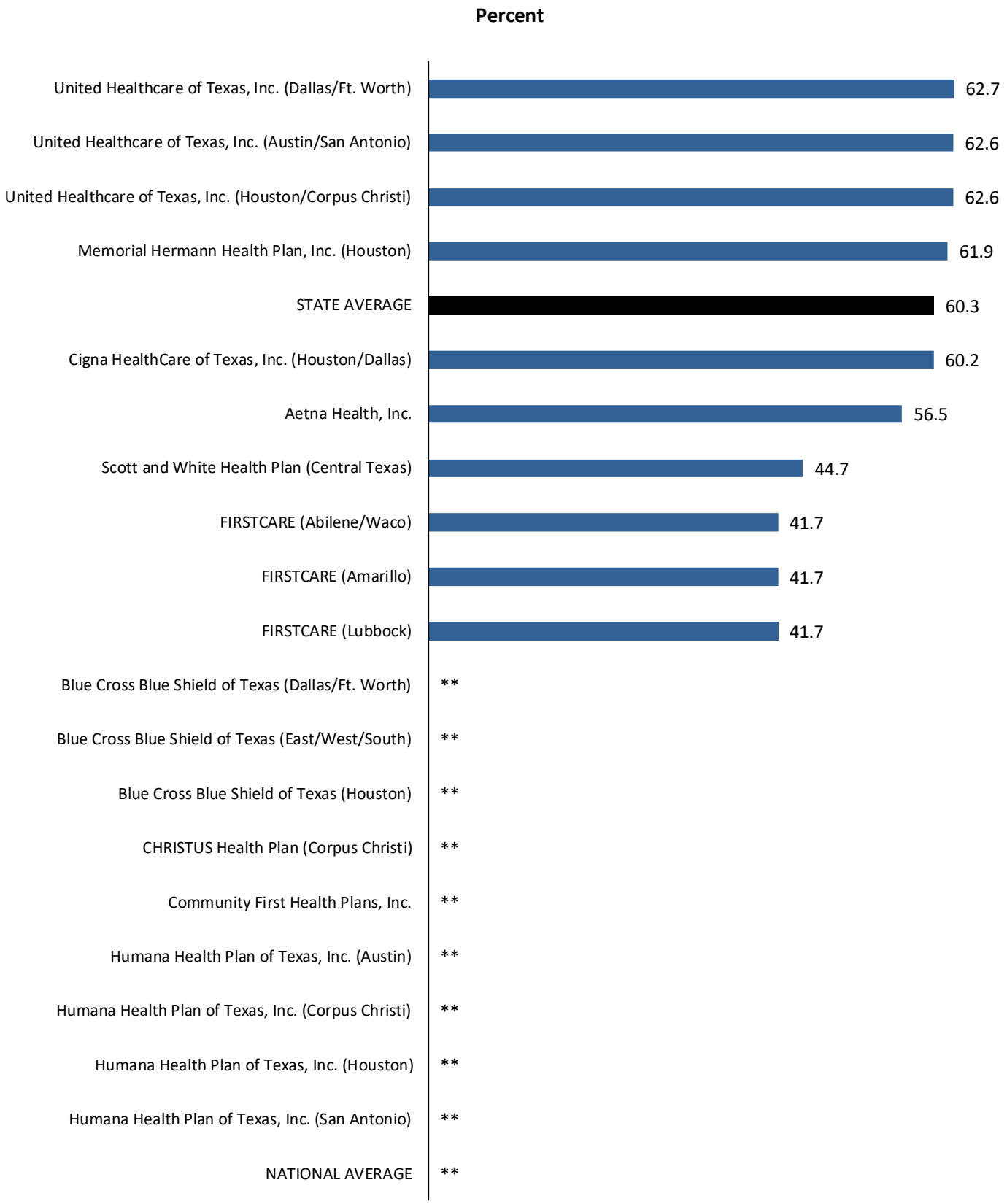
*** Value not established or obtained.*

Board Certification: Pediatricians



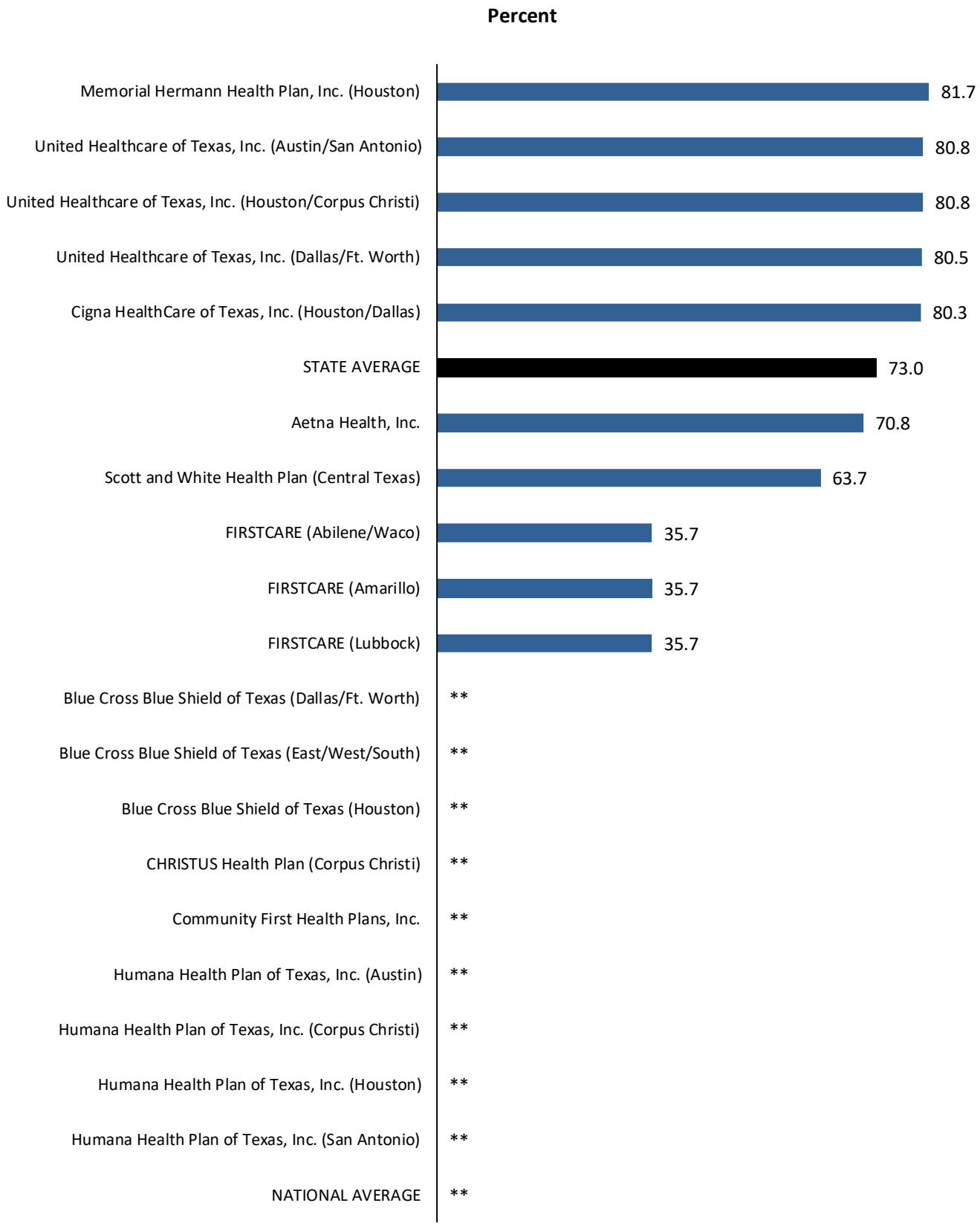
*** Value not established or obtained.*

Board Certification: Geriatricians



*** Value not established or obtained.*

Board Certification: Other Physician Specialists



*** Value not established or obtained.*

Total Membership by Product Line and Product Type

DEFINITION:

The percentage of plan members enrolled by product line and product type.

Texas HMOs offer 5 product lines (Commercial, Medicare, Medicaid, Marketplace, and Self-Insured) and 5 product types (HMOs, PPOs, POS, EPOs, and FFS). The following tables report the percentage of consumers enrolled in an HMO by product line and in any health plan by product type.

- Commercial members may be enrolled through an employer group policy or through an individual policy.
- Medicare Members are enrolled through a contract between the Centers for Medicare and Medicaid Services (CMS) and the health plan.
- Medicaid members are enrolled through a contract between the Texas Health and Human Services Commission (HHSC) and the health plan.

Product line percentages provide a sense of member demographics by providing information on which populations a specific plan insures. For example, commercial members generally fall between 18-64 (plus their under-age dependents). Medicaid members are primarily women and children. Medicare members are generally 65 and older.

Percentage of Plan's Members Enrolled in an HMO by Product Line

Health Plan Name	Commercial	Medicaid	Medicare	Marketplace	Others
Aetna Health, Inc.*	40%	0%	60%	0%	0%
Blue Cross Blue Shield of Texas (DFW)	41%	0%	0%	59%	0%
Blue Cross Blue Shield of Texas (East/South/ West)	41%	0%	0%	59%	0%
Blue Cross Blue Shield of Texas (Houston)	41%	0%	0%	59%	0%
CHRISTUS Health Plan (Corpus Christi)	0%	0%	0%	0%	0%
Cigna Healthcare of Texas, Inc. (Houston/ Dallas)*	100%	0%	0%	0%	0%
Community First Health Plans, Inc.*	100%	0%	0%	0%	0%
FIRSTCARE (Abilene/Waco)	100%	0%	0%	0%	0%
FIRSTCARE (Amarillo)	100%	0%	0%	0%	0%
FIRSTCARE (Lubbock)	100%	0%	0%	0%	0%
Humana Health Plan of Texas (Austin)*	7%	21%	73%	0%	0%
Humana Health Plan of Texas (Corpus Christi)*	7%	21%	73%	0%	0%
Humana Health Plan of Texas (Houston)*	7%	21%	73%	0%	0%
Humana Health Plan of Texas (San Antonio)*	7%	21%	73%	0%	0%
Memorial Hermann Health Plan (Houston)	100%	0%	0%	0%	0%
Scott and White Health Plan (Central Texas)*	100%	0%	0%	0%	0%
United Healthcare of Texas, Inc. (Austin/San Antonio)*	100%	0%	0%	0%	0%
United Healthcare of Texas, Inc. (DFW)*	100%	0%	0%	0%	0%
United Healthcare of Texas, Inc. (Houston/ Corpus Christi)*	100%	0%	0%	0%	0%

**Plans reporting HMO/POS membership combined. Others are HMO membership only.*

Percentage of Plan's Members Enrolled in an HMO by Product Type

Health Plan Name	HMO	PPO	POS	FFS	EPO
Aetna Health, Inc.*	100%	0%	0%	0%	0%
Blue Cross Blue Shield of Texas (DFW)	99%	1%	0%	0%	0%
Blue Cross Blue Shield of Texas (East/South/ West)	99%	1%	0%	0%	0%
Blue Cross Blue Shield of Texas (Houston)	99%	1%	0%	0%	0%
CHRISTUS Health Plan (Corpus Christi)	0%	0%	0%	0%	0%
Cigna Healthcare of Texas, Inc. (Houston/ Dallas)*	96%	0%	4%	0%	0%
Community First Health Plans, Inc.*	18%	0%	82%	0%	0%
FIRSTCARE (Abilene/Waco)	100%	0%	0%	0%	0%
FIRSTCARE (Amarillo)	100%	0%	0%	0%	0%
FIRSTCARE (Lubbock)	100%	0%	0%	0%	0%
Humana Health Plan of Texas (Austin)*	49%	39%	11%	1%	0%
Humana Health Plan of Texas (Corpus Christi)*	49%	39%	11%	1%	0%
Humana Health Plan of Texas (Houston)*	49%	39%	11%	1%	0%
Humana Health Plan of Texas (San Antonio)*	49%	39%	11%	1%	0%
Memorial Hermann Health Plan (Houston)	100%	0%	0%	0%	0%
Scott and White Health Plan (Central Texas)*	100%	0%	0%	0%	0%
United Healthcare of Texas, Inc. (Austin/San Antonio)*	100%	0%	0%	0%	0%
United Healthcare of Texas, Inc. (DFW)*	100%	0%	0%	0%	0%
United Healthcare of Texas, Inc. (Houston/ Corpus Christi)*	100%	0%	0%	0%	0%

**Plans reporting HMO/POS membership combined. Others are HMO membership only.*

Enrollment by Product Line: Commercial

DEFINITION:

The percentage of total members organized by gender and age for the commercial product line.

Membership data by gender and age can be used by purchasers and consumers to learn the enrollment characteristics of the health plan. The demographic data can help explain differences in the type of care provided and the total volume of services provided.

The following tables show the percentage of members in the plan by the following age group and gender categories:

- Males Age 0-19
- Males Age 20-44
- Males Age 45-65
- Males Age 65+
- Females Age 0-19
- Females Age 20-44
- Females Age 45-65
- Females Age 65+

Percentage of Male Members (Commercial Product) by Age Group

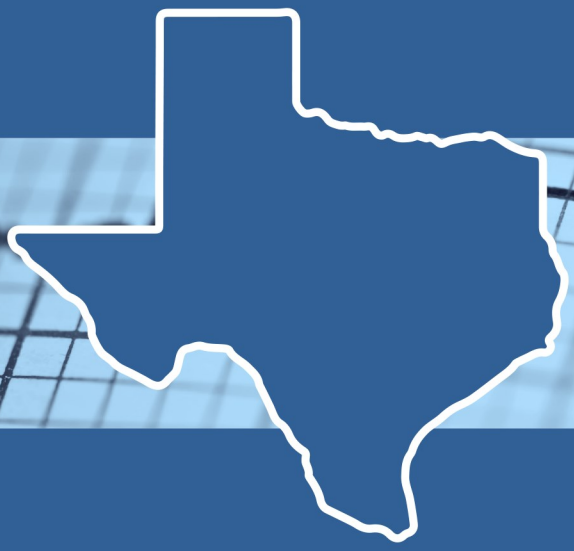
Health Plan Name	0--19	20-44	45-64	65+
Aetna Health, Inc.*	26.6%	38.5%	31.6%	3.3%
Blue Cross Blue Shield of Texas (DFW)	21.3%	46.3%	31.4%	1.1%
Blue Cross Blue Shield of Texas (East/South/West)	21.3%	44.2%	32.0%	2.5%
Blue Cross Blue Shield of Texas (Houston)	18.7%	48.0%	32.2%	1.2%
CHRISTUS Health Plan (Corpus Christi)	9.6%	4.3%	24.2%	62.0%
Cigna Healthcare of Texas, Inc. (Houston/Dallas)*	29.5%	36.6%	31.6%	2.3%
Community First Health Plans, Inc.*	32.0%	38.4%	24.6%	5.0%
FIRSTCARE (Abilene/Waco)	38.5%	32.0%	28.4%	1.2%
FIRSTCARE (Amarillo)	36.0%	32.3%	30.3%	1.4%
FIRSTCARE (Lubbock)	33.9%	35.1%	28.8%	2.2%
Humana Health Plan of Texas (Austin)*	21.6%	46.3%	29.6%	2.5%
Humana Health Plan of Texas (Corpus Christi)*	20.4%	40.2%	35.6%	3.8%
Humana Health Plan of Texas (Houston)*	21.0%	41.4%	34.5%	3.2%
Humana Health Plan of Texas (San Antonio)*	20.8%	39.1%	34.0%	6.1%
Memorial Hermann Health Plan	15.5%	45.7%	36.6%	2.2%
Scott and White Health Plan (Central Texas)*	29.0%	32.3%	32.7%	6.0%
United Healthcare of Texas, Inc. (Austin/San Antonio)*	27.4%	43.0%	28.1%	1.5%
United Healthcare of Texas, Inc. (DFW)*	17.3%	47.9%	33.4%	1.4%
United Healthcare of Texas, Inc. (Houston/Corpus Christi)*	19.5%	48.6%	30.2%	1.6%

**Plans reporting HMO/POS membership combined. Others are HMO membership only.*

Percentage of Female Members (Commercial Product) by Age Group

Health Plan Name	0--19	20-44	45-64	65+
Aetna Health, Inc.*	25.0%	42.0%	30.6%	2.4%
Blue Cross Blue Shield of Texas (DFW)	21.2%	48.1%	29.8%	0.9%
Blue Cross Blue Shield of Texas (East/South/West)	21.1%	47.7%	29.5%	1.8%
Blue Cross Blue Shield of Texas (Houston)	20.2%	50.6%	28.6%	0.7%
CHRISTUS Health Plan (Corpus Christi)	6.9%	5.6%	24.2%	63.3%
Cigna Healthcare of Texas, Inc. (Houston/Dallas)*	27.1%	38.2%	32.3%	2.5%
Community First Health Plans, Inc.*	23.3%	43.2%	28.0%	5.6%
FIRSTCARE (Abilene/Waco)	25.1%	37.5%	36.0%	1.5%
FIRSTCARE (Amarillo)	25.5%	35.8%	37.0%	1.7%
FIRSTCARE (Lubbock)	22.5%	40.0%	35.0%	2.5%
Humana Health Plan of Texas (Austin)*	21.5%	47.4%	29.1%	2.0%
Humana Health Plan of Texas (Corpus Christi)*	18.8%	43.4%	35.2%	2.6%
Humana Health Plan of Texas (Houston)*	22.4%	41.9%	33.5%	2.2%
Humana Health Plan of Texas (San Antonio)*	19.9%	40.8%	33.8%	5.5%
Memorial Hermann Health Plan	18.1%	47.5%	33.4%	1.0%
Scott and White Health Plan (Central Texas)*	22.1%	36.5%	36.1%	5.3%
United Healthcare of Texas, Inc. (Austin/San Antonio)*	22.6%	44.8%	31.5%	1.2%
United Healthcare of Texas, Inc. (DFW)*	19.5%	47.5%	31.7%	1.4%
United Healthcare of Texas, Inc. (Houston/Corpus Christi)*	21.6%	49.6%	27.6%	1.2%

**Plans reporting HMO/POS membership combined. Others are HMO membership only.*



Section VI

Additional Information

Methods and Statistical Issues

The Healthcare Effectiveness Data and Information Set (HEDIS®) consists of standardized performance measures used to compare the quality of care of managed care organizations. The National Committee for Quality Assurance (NCQA)— a private, nonprofit organization— developed and maintains HEDIS®. NCQA convenes national healthcare experts to guide the selection and development of HEDIS® measures based on three primary criteria: relevance, scientific soundness, and feasibility. The performance measures reflect many current public health issues affecting Americans, including cancer, heart disease, smoking, diabetes, and the care of children and pregnant women.

Texas law requires basic service HMOs to report HEDIS® measures to the Department of State Health Services (DSHS) through the Texas Health Care Information Collection (THCIC) on an annual basis. THCIC is a part of the Center for Health Statistics (CHS) division of the DSHS.

Each year THCIC collects a subset of HEDIS® measures in Texas. THCIC uses the following principles to guide its recommendations:

- The measures must reflect the types of plans and products currently available in the Texas marketplace.
- The measures must translate into meaningful information for Texas residents.
- Sufficient encounter information must be available. If a majority of plans cannot report a specific measure due to a low number of members qualifying for the measure, the measure is not required to be reported.
- The reporting requirements must minimize duplication in reporting to other state agencies.
- The reporting requirements and technical specifications must be consistent with those of NCQA.

To accommodate differences in HMO data systems and technical capabilities, HEDIS® 2019 gives plans a choice of 2 methods to calculate performance measures: 1) an administrative records method or 2) a hybrid method. The administrative records approach involves three steps. First, all records in a health plan's administrative database are queried to determine the eligible population for a certain measure. This becomes the denominator for the measure. Second, the selected records are reviewed to identify the members who utilized the service/ procedure. This number is included in the numerator. Third, the members with a contraindication to the service/ procedure are excluded from the denominator. The hybrid method utilizes a random sample of enrollees for the denominator. The selected records are reviewed to identify the individuals who used the service. NCQA has developed a systematic sampling scheme for health plans who choose to use the hybrid method.

A third data gathering and analysis method, survey research, is used for the "Medical Assistance with Smoking and Tobacco Use Cessation" and "Flu Vaccinations for Adults 18-64" measures in the *Effectiveness of Care* domain. The standardized survey instrument employed for HEDIS® 2019 is the Consumer Assessment of Healthcare Providers and Systems, Version 5.0 (CAHPS® 5.0H). The survey asks consumers to score various aspects of their experience with their health plan. Health plans must contract with independent survey vendors certified by NCQA to administer the survey. A report on the survey measures, ***Comparing Texas HMOs 2020-2021***, is available on OPIC's website at: **www.opic.texas.gov**.

Plan members must be continuously enrolled to be counted for rate denominators. Continuous enrollment criteria typically require an individual to be an active plan member for the duration of time under review— usually 1 year. One break in enrollment of up to 45 days per year is usually allowed to account for a change in enrollment.

Methods and Statistical Issues

NCQA developed the sampling methodology using established practices, however there is a small chance that the sample does not represent the underlying population. When interpreting data, keep in mind that many HEDIS® measures are best understood in the context of others. It is always more meaningful to compare health plans across a group of related measures than any single measure.

Certified auditors review HEDIS® results using a process designed by NCQA. Data not certified through this process, or not submitted as required by NCQA, are denoted as "NR" (not reportable). Data that may meet NCQA audit standards but are calculated from fewer than 30 denominator observations are designated as "NA" (not applicable). Plans that fail to report a measure by service area as statutorily required are designated as "FTR" (failure to report).

Measures from *Effectiveness of Care* and *Utilization* domains were tested using a 95% confidence interval to determine if they differ significantly from the average of all HMOs in Texas.

For ease of computation, the formula for calculating the 95% confidence interval around an organization's HEDIS® rate is:

$$\text{lower} = p - 1.96\sqrt{\frac{p(1-p)}{n}} - \frac{1}{2n}$$

$$\text{upper} = p + 1.96\sqrt{\frac{p(1-p)}{n}} + \frac{1}{2n}$$

For example, suppose the organization has a sample size of 96 eligible women for its "Cervical Cancer Screening" rate. Of these, 50 receive a Pap test during the year. The calculation would proceed as follows:

$$p = \frac{50}{96} = 52\%$$

$$\text{lower} = .52 - 1.96\sqrt{\frac{.52(1-.52)}{96}} - \frac{1}{192} = 41.5\%$$

$$\text{upper} = .52 + 1.96\sqrt{\frac{.52(1-.52)}{96}} + \frac{1}{192} = 62.5\%$$

Where p= the organization's rate and n= the sample size.

The user can be 95% certain that the organization's true Pap test rate is between 41.5% and 62.5%.

The summary tables (pages 8-16) report plan performance on specific measures in relation to the Texas state average. Plan performance is "equivalent" to the state average if it is not rated as statistically different from the average of all plans in the state (i.e. the interval includes the state average). Otherwise, the plan's performance is reported as either better (+) or worse (-) than the state average.

Methods and Statistical Issues

Results of HEDIS® statistical significance testing should be interpreted with care. Statistical tests account only for random or chance variations in measurement. HEDIS® does not control for underlying differences in plan population characteristics such as age or health status. For some measures, the difference between HMOs may represent differences in quality of care, while others may represent a different mix of member enrollment.

This publication reports benchmarks from NCQA's National Quality Compass®. NCQA's national averages are based on HEDIS® data voluntarily reported to NCQA by hundreds of health plans throughout the country.

Please send questions or comments to:

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